Candie Hailey came into jail with about the worst label possible: baby killer. In 2012, Ms. Hailey ran into a group of women she knew on the streets of the South Bronx. They exchanged words, and a fight ensued, during which the toddler of one of the women was injured, suffering a cut and a fractured skull. The women alleged that Ms. Hailey attacked them and the toddler with a knife, leading to a charge of attempted murder for Ms. Hailey, who was held in jail on $500,000 bail. As she related to Jake Pearson of the Associated Press, almost every day she spent in the Rose M. Singer Center jail on Rikers would bring conflict and violence relating to this charge. A fighter by nature, Ms. Hailey did not respond to the abuses of jail meekly. During her three years in jail, Ms. Hailey would spend over two years in solitary confinement, including 27 of her first 29 months. She received her first infraction and first stay in solitary confinement in her second month of jail, for arguing over who should clean a shower. A couple of weeks later, Ms. Hailey cursed at a guard, and during the resulting physical altercation, she spit on the officer. That interaction landed her in solitary for 95 days, but the sentence was almost irrelevant. Ms. Hailey’s response to the stress and violence of solitary was to act out against her surroundings, resulting in even more infractions and “box” time with each passing month. New infractions occurred for cursing officers, blocking her cell window, failing to obey commands, and splashing staff with toilet water. In some instances, Ms. Hailey would smear her cell with feces, with the mind-set that “If you’re gonna treat me like a dog, I’m gonna act like one.”
While the experiences of Candie Hailey seem extreme, they’re a foreseeable result of how correctional settings work. As paramilitary operations, jails and prisons are designed to thwart transparency and undercut any priorities that come into conflict with “security.” One stark and deadly consequence of this approach is the erosion of the health mission by the security service. Almost nobody who works in corrections or correctional health ever uses the terms “dual loyalty” or “human rights,” but these concepts are absolutely required to understand how preventable death and disability are so common among our patients. The essence of dual loyalty is that despite being a doctor or nurse or social worker, our individual interactions with our patients in jail or prison are influenced by the security setting around us. Most of the time, dual loyalty exerts a mild influence that we might not notice, such as rethinking writing an order for an asthma inhaler (which requires front- instead of rear-cuffing) or for a cane (which could be used as a weapon). Maybe the most dramatic and tortured aspect of dual loyalty in correctional health is clearance for solitary confinement. This process, which occurs at almost every American jail and prison, is at the core of human rights problems in correctional health, and the influence is not just on individual providers but also on the overall functioning of every correctional health service.

One of the striking features of Ms. Hailey’s case is how the health service responded to obvious and repeated health emergencies and crises. During the 27 months of constant solitary, Ms. Hailey also at times inflicted violence against herself. She repeatedly swallowed odd objects, cut herself, and hit her head on the walls. These acts of self-harm elicited medical treatments for the injuries, mental health evaluations, and brief periods on suicide watch. In virtually every encounter with health staff, her actions were judged to be manipulative, aimed at escaping solitary confinement. These assessments give us a glimpse of the core of dual loyalty and how it erodes the health mission in jails and prisons. Health staff are asked to decide whether acts of self-harm are true suicide attempts or not. If their clinical assessment is that the patient was not suicidal or psychotic, then the patient is essentially found fit to be in solitary. For patients with schizophrenia or bipolar disease, the response was more clear-cut: these patients could be removed from solitary and then treated in the hospital. But few hospitals would admit patients like Ms. Hailey, at least for more than a day or two. This left the jail to manage
her behaviors and the mental health staff to choose between the only options presented: was she a malingering or a psychotic patient who needed urgent mental health care? It’s an absurd binary and does nobody any good.

**Dual loyalty in correctional health** has been written about in the past by people outside jails and prisons, including my own current organization, Physicians for Human Rights. These reports have identified the caustic impact that security priorities can have on health staff, but these discussions have been largely absent from the operations of correctional health, where the problem exists essentially unchecked. Inside the walls of US jails and prisons, dual loyalty is so widespread and accepted that only when a patient dies are questions asked. Generally, there is a quick response to condemn an individual nurse or doctor for failing to do their job, but with no discussion of the pressures that led them and thousands of others to stray from the path of patient care. Some of the most shocking cases involve patients who die while being restrained in a chair or being held in a cell, but who are under medical “monitoring.” These cases often reveal that health staff cease acting in the best interests of the patient because their frame of reference is driven by the security perspective. The 2013 death of Christopher Lopez in Colorado’s San Carolos Prison is one of these instances. Mr. Lopez, a schizophrenic, was sentenced to two years in prison for trespassing but had an additional four years (with extensive solitary confinement) added to his sentence for assaulting a corrections officer while in prison. During his stints in and out of solitary, Mr. Lopez acquired the label of being a noncompliant patient and one who required “special controls,” meaning enhanced restraints. On the day of his death, Mr. Lopez refused to obey a command to move toward the door of his cell. This seemingly minor act of defiance (or misunderstanding) can be perceived as a serious sign of disrespect by security staff. As a result of Mr. Lopez’s inaction, a probe team entered the cell with riot gear, restrained him, and placed him in a special restraint chair with a spit mask over his face. Medical staff were present for this episode and participated by administering psychotropic medication and remaining in the cell with security staff. Video of this episode shows Mr. Lopez having a grand mal seizure while health and security staff watch and do nothing more than place him on the ground when he becomes unresponsive. At some point during
the video, health staff can be heard asking Mr. Lopez, “What are you doing? Why are you doing this? I can see you breathing.” After another 30 minutes of unresponsiveness, health staff discovered that Mr. Lopez had stopped breathing, and they initiated CPR. These cases of jail patients dying in full view of health staff are tragically common. Shortly after leaving Rikers, I reviewed the case of a young man who died in similar tragic circumstances in the St. Luis Obispo jail. This 36-year-old man, Andrew Holland, a longtime mental health patient, also met his death after 48 hours in a restraint chair while health staff administered meaningless interventions.

Even when health staff are not actively part of causing a death, they may shy away from doing their jobs in critical situations. One such case involved the 2010 death of a schizophrenic inmate, Leonard Strickland, in New York’s Clinton State Prison. Nothing was known publicly about the case until the New York Times reported on the death and obtained video showing correction officers dragging a lifeless Mr. Strickland across the floor after a brutal use of force within clear view of a nurse. As Mr. Strickland lay on the floor close to death, with the nurse standing to the side, Department of Correction officers continued to yell “Stop resisting!” In 2014 I saw a patient newly arrived from the same prison system with a similar story. He reported being assaulted over several days by a group of corrections officers, and when he arrived at Rikers, he essentially fell out of the bus with serious injuries and was transported directly to the hospital. He related to me that during the several days of assaults he was taken to a jail clinic, where the health staff never asked him how he became injured, but instead asked the corrections officers how they should document the cause of injuries in the medical records.

In 2012, we published a paper in which we asserted that without integrating core human rights and medical ethics concepts like dual loyalty into the correctional health mission, the health service would fail. Our position then (and now) was that even with great correctional health staff, the right policies and procedures, and plenty of resources, the nature of corrections is to wear away medical decision making and to bend the health service into a tool of the security service. Over a year, we developed a structure for incorporating human rights into our health system, including practical tools like assessments of deficiencies linked to human rights issues and a human rights quality improvement committee. Our first proj-
ect, a dual loyalty assessment based on staff and patient interviews, as well as reviews of patient records, led us to develop a dual loyalty training for all health staff. Ms. Hailey came into the jail system as we were embarking on this work, and her experiences reveal the failures of the health service to act on her behalf.

In health care, we understand that patients with behavioral health problems like borderline or narcissistic personality disorder may not be truthful and may act inappropriately. As a medical student, I can recall the oversimplified description of personality disorders being clustered into categories of patients who were excessively “wild, weird, and worried.” Later, as a resident at Montefiore, I can recall seeing a clinic walk-in patient for a simple complaint about his eyes, at which point he launched into a fantastic and angry story about how his eyes moved around in his head every night and our clinic had ignored his complaints. I asked a series of questions about the concerns he had with his eyes, as well as a standard set of questions about his overall health. Unlike other patients I’d cared for who were psychotic or having some other profound decompensation, this patient seemed to understand and appreciate the world around him, but in that first encounter I felt overwhelmed by the story he was telling me and his aggressive and threatening demeanor. When I presented this patient to my preceptor, Dr. Joe Deluca, he quickly focused on how the patient and I had interacted, starting with, “How did you feel sitting in the room with him?” I told him that after a few minutes I felt like my skin was on fire and I wanted to bolt out of the exam room. “That’s what happens when a patient with a personality disorder runs into a doctor who doesn’t see it,” he replied. His counsel was for me to take this patient on as my own and see him more often than I normally would. After a couple of months following this plan, the patient and I settled into a rhythm of shared expectations about what we would cover in each session, and his concerns about his eyes gave way to some other health issues that he hadn’t ever sought care for. Importantly, the way I felt on my initial encounter with him could have cemented the dynamic between us, which would have led me to dread every further contact with him as a patient. Also, not knowing how to process the strongly negative emotional response I had to him during that first encounter would have led me to focus on the eye complaint being false and to ratchet up my assessment about him being a malingerer or a liar.
This dynamic is central to the mission of mental health professionals, but for those of us in primary care and medical specialties, it’s easy to ignore or sidestep our own emotional responses to patients when they aren’t truthful, and these dynamics are critical to whether the patient gets good or bad care from us. Those of us fortunate enough to train with mentors like Dr. Deluca learn that fantastic stories and aggressive demeanor are often part of a patient’s accumulated trauma and mental health status. We fail as doctors when we take these interactions personally and don’t integrate them into our clinical formulation. But in jail, this approach to understanding the patient is often undercut by pervasive focus on punishment. Health staff find themselves advocating for punishment, sometimes as a prerequisite to clinical treatment, even when that punishment is solitary confinement. This is essentially where Ms. Hailey found herself in the jails. As she had difficult encounters with health and security staff alike, she was locked into adversarial dynamics that hardened over time.

I was once chatting with a patient who had considerable mental health issues, on the same solitary confinement unit that Ms. Hailey was on. An experienced mental health staffer approached us and said to her, “Tell him what you did to be in there, and why you have to stay in there a little longer before you can come out to group [therapy].” This punishment mentality is unfortunately pervasive among correctional health staff and their leadership. In 2011, my boss, Dr. Amanda Parsons, and I were listening to a pitch from a for-profit correctional health group interested in providing care in the NYC jails. Their medical director told us about a great new diabetes quality improvement project that he’d implemented in a local jail. Basically, patients were informed of their plan of care, and part of their incentive to participate was that they would be referred to security staff for infractions if they didn’t participate. On a different occasion, I visited another jurisdiction’s mental health lockup with Health Commissioner Mary Bassett and our medical director, Dr. Ross MacDonald. We observed in horror as mental health staff used their “treatment team” meeting to refer patients for infractions with security staff. This co-opting of health staff for the security mission erodes the ability of the health staff to really see their patients objectively and is unfortunately more the norm than the exception in US correctional health settings.

Dual loyalty also flourishes because even small measures of inde-
pendence of health staff can be eroded and dominated by the security perspective. One Sunday afternoon I received a call that a patient had died in our medical infirmary. This wasn’t an altogether unheard-of event, since we housed some of our sickest patients in the infirmary. But the call I received indicated that the patient, Ronald Spear, who was sick enough to require hemodialysis to live, had been involved in a use of force. I headed into Rikers and, once there, found the deceased on the floor, DOC setting up an investigation, and a very different set of stories on what had happened. I focused on the care he’d received before his death, while the DOC investigators and Bronx NYPD homicide detective on the scene took over the official investigation into the use of force. The story that would emerge was that Mr. Spear had a verbal altercation with a DOC officer that escalated to pushing. The DOC officer then punched him in the face and slammed him to the ground, kicking him in the head several times before kneeling over his body and snarling, “Remember that I’m the one who did this to you.”

This happened in our infirmary, not in some faraway intake pen, reminding everyone involved that there was no part of the jails that wasn’t controlled by security staff. For health staff weighing how much to advocate for a patient, these types of reminders often serve to tip the balance away from standing up for a patient and toward the corrosive effect of dual loyalty.

Ms. Hailey’s actions during her time in the solitary unit can be viewed as part of her mental health issues, but they can also be viewed as basic survival instincts. The stress of solitary confinement can drive anyone to extreme behaviors in an attempt to escape their cell, even for a short ride to the hospital or transfer to the jail clinic. These actions often escalate as the patients are labeled as malingering or goal oriented and need to take more and more extreme actions to achieve the same result. Both security and health staff become numbed to the physical and mental toll that this setting takes on patients. Five Omar Mualimm-ak, a friend and colleague, once spent over five years in the box both in Rikers and upstate in the New York prison system for nonviolent infractions. He writes,

There was no touch. My food was pushed through a slot. Doors were activated by buzzers, even the one that led to a literal cage directly outside of my cell for one hour per day of “recreation.” Even time had no meaning in the SHU. The lights were kept on for 24 hours. I often found myself
wondering if an event I was recollecting had happened that morning or days before. I talked to myself. I began to get scared that the guards would come in and kill me and leave me hanging in the cell. Who would know if something happened to me? Just as I was invisible, so was the space I inhabited. The very essence of life, I came to learn during those seemingly endless days, is human contact, and the affirmation of existence that comes with it. Losing that contact, you lose your sense of identity. You become nothing.  

Mr. Mualimm-ak now runs a nonprofit organization focused on advocating for the millions of people currently and formerly incarcerated in the United States. For him, even healthcare encounters were so depersonalized that they didn’t bring relief from the isolation of solitary confinement. “For the five years I spent in the box, I received insulin shots for my diabetes by extending my arm through the food slot in the cell’s door. (‘Therapy’ for prisoners with mental illness is often conducted this way, as well.) One day, the person who gave me the shot yanked roughly on my arm through the small opening and I instinctively pulled back. This earned me another ticket for ‘refusing medical attention,’ adding additional time to my solitary sentence.” Mr. Mualimm-ak became one of the core advisors to our human rights agenda in the correctional health service, and he repeatedly identified the tangled roles our health staff played in solitary confinement units like the one Ms. Hailey was held in as the epicenter of human rights and dual loyalty concerns.

Beyond the psychological stress of solitary confinement, these settings often had deplorable physical conditions. In Ms. Hailey’s unit flies often swarmed in the solitary cells, with patients constantly swatting them away. Sometimes a patient would block their toilet, either in protest of something specific or through general frustration, and water and sewage would flow into neighboring cells. Patients on these units would smear their own feces inside the cells in acts of protest. Plumbing repairs were often slow in coming, and they were quickly undone. In my work I have encountered a fair number of patients who smeared—every one of them in a solitary cell. This act alone should help us consider just how extreme the human response to solitary confinement can be. The deplorable conditions and human suffering create indelible memories for anyone with experience on these units.
The loss of trust between correctional patients and health providers is the central consequence of dual loyalty, and it leads to considerable avoidable morbidity and mortality. The labeling that Ms. Hailey experienced virtually guaranteed that health staff would lack objectivity in their assessments and care. One of the enduring truths of our case reviews is that once a patient receives a label as a malingering or otherwise problematic patient, it’s extremely unlikely that staff will approach him or her objectively. One of the most profound dual loyalty cases I ever saw was that of a man injured during a use of force. His hip was fractured, and the patient was seen by a nurse and told that he would need to go directly to the hospital. The doctor who saw him was told by security staff that he was faking his symptoms and that he just wanted to go to the hospital. In the part of the doctor’s note that recorded the physical examination, there was a textbook description of a fracture: limb shortening and rotation. But in the assessment/plan part of the note, the doctor wrote that there was unclear evidence of hip fracture and that the patient should be put into a wheelchair and taken in a van to the X-ray on Rikers. This plan was impossible because of the pain involved in sitting in a wheelchair, and it was also completely unnecessary given the information gathered by the doctor. The provider’s mind was made up by information from the security service rather than the patient’s actual signs and symptoms.

During Ms. Hailey’s incarceration, we opened the Clinical Alternative to Punitive Segregation unit for seriously mentally ill patients. We had succeeded in eliminating solitary for one vulnerable group. But because Ms. Hailey wasn’t assessed as being seriously mentally ill, she spent limited time in this new unit. My own knowledge of her case came when two dedicated patient advocates took up her cause. Jennifer Parrish, director of the Urban Justice Center’s Mental Health project, and Jane Stanicki of Hour Children both began to visit with her regularly and provided feedback about the care she and others required and the conditions on the women’s solitary unit. Our own director of projects, Cecilia Flaherty, joined in the regular visits to this unit, working with the mental health staff of Corizon and the security staff to try to maximize out-of-cell time and access to group therapy and other programs. These visits brought some improved conditions and a touch of humanity to the women viewed as most problematic, but they also revealed how toxic the solitary unit was to our own staff and their relationships with their patients. We had asked staff to work in these
units for years without preparing them for the realities of dual loyalty or providing the tools to address these concerns. Without support or training, health staff followed the lead of their security colleagues for guidance on how to interact with patients. In retrospect, this shouldn’t have been a surprise. Security staff were the ones who protected health staff and allowed them to provide care. Health staff would stop me or Cecilia with the same complaints as the security staff had: “You’re being manipulated by these women,” or “They’re lying to you and just trying to get out of their punishment.” While it was true that many of these and other patients didn’t tell the truth or worked to split the staff against each other, being in the jail setting brought out the same type of moral judgment from health staff that we often saw in the DOC staff.

Ultimately, Ms. Hailey was found innocent of the charges against her, and she returned to the community, having accumulated an unimaginable amount of trauma and depersonalization during her three years of incarceration. She struggled to reacclimate to life outside the jail. Ms. Hailey has attended several oversight meetings held by the New York City Board of Correction and spoken on the horrible experiences and consequences of solitary confinement. At one of her appearances, Ms. Hailey reported that she tried to kill herself on a regular basis, but that staff ignored her and treated her like an animal.10

Incorporating human rights into the health operation of the jails has taken us down an uneven but rewarding path. As we learned more about injuries and solitary confinement, it became clear that we needed to develop a structured response to the observation that the jail setting sometimes harms our patients. While our mission was to assess and reduce the health risks of incarceration, this was not a mission welcomed by those around us in the security service, city government, or even all of the health service. Many of our senior team had learned to conduct forensic evaluations of torture survivors at Montefiore, so that asylum seekers could bring medical evidence of abuse into their asylum hearing. This type of human rights training was critical to our view of the problems, but documenting abuse that occurred thousands of miles away and years earlier is a far cry from seeing and documenting problems down the hall, with patients who are confined to their sites of abuse. As the leaders of the jail health service, we were on the inside of this system, and we immediately sensed the many
layers of cultural and political resistance to our focus on human rights as a part of the health mission.

One challenge to the human rights construct was that it didn’t always track with how American health systems address problems. Healthcare improvement in the United States is built on a standardized approach that relies on finding and fixing problems. For individual patients, there’s something called a SOAP note that is used across health care, with “SOAP” standing for “Subjective, Objective, Assessment, and Plan.” The notion is that we ask for the patient’s input in the subjective part of the encounter, then get our own objective data from sources such as a physical exam and vital signs, followed by our assessment (usually the diagnoses), and then formulate a plan. At the macro level, health systems are set up to find and address health problems quickly, because any delay in acting can cause morbidity or mortality. All of this makes sense. Even how we improve things in health care is action oriented. We use quality assurance processes to look for problems in almost every area of care and quality improvement interventions to come up with new workflows, policies, and trainings to fix those problems.

Juxtapose these systems to human rights, where the initial step of identifying and documenting a problem is sometimes the only measure that can be taken for a while. In my new position at Physician for Human Rights, I’ve spent a fair amount of time in Iraq and Bangladesh working on the abuses suffered by the Yazidi and Rohingya, respectively. In that work, we’re focused on documenting the truth of mass crimes committed against these ethnic minorities, and our hopes for accountability are pretty far down the road. In Syria we document attack after attack on hospitals and doctors, and it’s unclear when there will be any accountability for those war crimes. But without accountability there can’t be any justice, so we and others work to collect forensic evidence, and in places like Rwanda and Yugoslavia, there has been some recent accountability. The killing fields of Northern Iraq and Rakhine Myanmar are certainly worlds away from Rikers Island, but every correctional health system needs the capacity to document abuses that they may not be able to address. Unfortunately, without correctional health leaders who believe in the human rights imperative, this critical work is sadly but quickly scrubbed out from these systems.

The challenge of providers buying into human rights isn’t just about the speed with which the problems can be fixed, however. Health care is an
industry and culture that has its own language, and introducing a new set of principles requires using accepted language. As we developed a structure in 2011 to focus our work on human rights, our first practical move was to create a human rights quality improvement committee. This simple action mated the new ideas of human rights to the quality improvement apparatus that was already viewed as credible by our health staff. This group is composed of senior clinical and operational staff, and the first issue the committee identified was the need for an assessment of dual loyalty in our health service. Before that, there was an echoing silence around dual loyalty in correctional health. We knew that it was omnipresent, but there was no evidence, because it had never been addressed. The assessment would focus on where it was most pervasive. To assess dual loyalty, we looked at the interaction between health staff and their patients who were held in solitary confinement. First, we analyzed the medical notes of 24 patients in solitary. All told, those patients had 5,602 medical notes. Among them, we found 651 (12.2%) notes that included work or comments that were not in the patient’s interest—the definition of health care’s vulnerability to dual loyalty. The most common finding (312 notes) was that the patient’s behaviors were “goal directed” or exhibiting “secondary gain” to influence their housing status. One note read, “Inmate is well known to mental health and all recent notes indicate he is threatening to harm himself if put in a cell. He owes 109 punitive segregation days and wants to be placed in [clinic]. He has reported that he will swallow a razor, batteries, cut himself, etc., if placed in a cell. He is at high risk for repeating self-injurious gestures to get himself moved, but low risk for actual suicide.” These results laid out the false dichotomy that our staff were trapped in, trying to use their clinical skills to decipher whether someone was harming themselves just because they wanted out of solitary or because they were really mentally ill. Putting aside the fact that being a mental health provider isn’t the same as being a lie detector, we found that staff perceived the “goal-oriented” actions of people who just wanted out of solitary as not worrisome and the actions of psychotic or otherwise more mentally ill people as more serious. The death of Jason Echevarria helped to put the lie to this distinction. He was certainly engaged in a goal-oriented act, and he died nonetheless.

Our next step to characterize our dual loyalty concerns was to host a series of focus groups with mental health staff. These sessions revealed that
over one-third of these providers felt that their work regularly caused them to compromise their ethics (higher than the 24% of other health staff) and that their work in solitary was not real mental health work and damaged their relationships with patients. These staff reported that working in a setting where they were part of punishing a patient, or where they sometimes couldn’t deliver evidence-based care, damaged their identity as healthcare providers. Mental health staff who clear patients for solitary confinement feel the weight of participating in this process. One mental health staff member reported, “Even though I am not a believer in solitary confinement as punishment, I sometimes feel that the least harmful path is to return a personality disordered person to solitary in this scenario. This is very personally distressing to me and situations like this leave me with a negative impression of the work I do and my workplace.”

Our final step in the dual loyalty assessment was to have qualitative interviews with 19 patients who had committed self-harm, mainly in attempts to get out of solitary or to protest against conditions in solitary. These patients viewed the health service as deeply compromised in its ability to provide actual medical care to them. One patient reported, “The doctor is not for us, [security staff] influence them [mental health staff] to clear people who are not supposed to be cleared.” Another patient reported that he was “afraid of being in a cell alone and says his fear of being alone in his cell . . . will lead him to try to cut and hang himself as well as ingest soap whenever possible.”

With this information in hand, we set about developing a training for all clinical staff on the issues of dual loyalty. We created an online module that introduced dual loyalty and other human rights concepts through a series of clinical scenarios that had actually occurred in our jail. Staff were given options for how to address the scenarios and were asked for feedback based on their own experiences. The scenarios included a patient whom DOC wanted to punish with solitary confinement despite having harmed himself in the past when punished this way, a request from a patient for condoms in jail (which is allowable by policy), and an incident in which a patient reports different causes of an injury than correctional officers. In the injury report scenario, a patient was in a clinic cubicle, with correctional staff insisting that he sign a form that stated he had been injured in a fight with another inmate, while he complained to the doctor that he had been
injured by a guard. In this circumstance, the doctor was able to note the patient’s version in our electronic medical record without the correction officer knowing so that it was referred to us at the senior level, defusing the immediate pressure. A total of 93 percent of respondents indicated that they had encountered or heard of this type of scenario. The final scenario involved patients being brought into the jail clinic restrained on stretchers and being beaten by correction officers in full view of health staff (see chap. 2). When asked for possible responses to this scenario, one health staffer reported, “Tell DOC staff this is highly inappropriate and threaten to report this to all higher authorities in which their jobs may be in jeopardy. Such beatings (if done at all) should never take place in public.” A total of 16 percent of respondents indicated that they had encountered or heard of a similar event.

This scenario raised the persistent issue of our stretchers being used to restrain inmates for abuse. Every jail clinic has a stretcher with emergency gear, such as defibrillators and oxygen tanks, so that we can respond to emergencies outside the clinic. Like one would see in hospitals, nursing staff check the equipment every day and note that everything is present and functional. In the jails, DOC staff occasionally come into the clinic and grab our stretcher to take out for their own use, usually to restrain an unruly inmate. In these circumstances, they don’t call a medical emergency or ask for our staff to accompany them. Not only do we lose our stretcher so that we can’t respond to emergencies, but our medical equipment is also used for unclear purposes, sometimes including outright assault of restrained patients. As long as I’ve worked in the jail system, we’ve worked to get DOC to stop this practice, and despite unending memos and reminders from their senior leadership, the practice continues. When this happens, our stretcher usually turns up in a random part of the jail hours or days later, sometimes damaged, making it impossible for us to properly respond to true medical emergencies in the interim. Early in my tenure, I got one of these calls from a jail about a stretcher being taken by DOC staff. I went to the jail and found a probe team of about 10 officers in riot gear headed down the hallway with our stretcher. I stood in the middle of the hallway and signaled to the captain that they needed to return the stretcher. After he and I barked back and forth and his officers threw a few remarks my way, he relented and gave it back, and I wheeled the stretcher away under the glare of the probe team.
After taking the stretcher to the clinic, I went to the housing area where the officers were headed and found a restrained patient on the ground, kicking and with officers standing around. It was clear that the officers needed a safe way to transport this person, and I made the humbling decision to go get the stretcher myself and bring it back for the officers to use to transport the patient to the jail intake. I ran and got the stretcher and suffered a long 15 minutes of insults from the officers for sticking my nose into their business. Afterward, I directed our staff to give our old stretchers to DOC so they could have their own transport option that didn’t harm our ability to respond to medical emergencies. The risk that these stretchers would be used for nefarious purposes didn’t escape me, but the reality was that DOC did seem to have a legitimate need to transport people who had been restrained. But today many of these stretchers remain unused, and the security staff continue to take our stretchers when they want them.

Near the end of my time at Rikers, I encountered a glimmer of hope on this front, though: I responded to an emergency in a hallway where an agitated patient, who had just been teargassed, was on the floor, rear-cuffed and yelling that he couldn’t breathe. He was surrounded by a probe team of security staff, and when I approached with our stretcher, DOC simultaneously rolled in with one of the stretchers that we had given them. Because the patient was stating that he couldn’t breathe, I asked DOC to back off so I could get him up and on our stretcher to go directly to the clinic. Unfortunately, a week later, I received word that DOC staff had returned to their practice of grabbing our stretcher for nonmedical use instead of using the one we’d given them. The stretcher issue is a good indicator of how imbalanced the power dynamic is, and how sticking up for our independence as a health service can bring us into conflict with security staff and their own needs. DOC managers should train and equip their staff to transport unruly people without removing essential medical equipment, but the low priority of the health mission and lack of effective management of DOC allow this problem to persist.

Our dual loyalty trainings revealed another disconnect closer to home: the cultural differences between human rights and medicine. The first lesson of human rights is to document everything, even when there’s no prospect for change or accountability. This is a tough sell for doctors and nurses who want to diagnose, treat, and resolve every issue they encounter.
This disconnect is amplified when documenting or reporting abuse comes at a personal price. One staffer reported, “Part of dual loyalty is threats from DOC if we go above and beyond to protect a patient. We are then in a position that the officer may take ‘extra long’ to respond to medical staff being assaulted by a patient due to medical staff reporting human rights violations. We have to bear in mind the safety of the patient as well as our own safety.”

A central effort in our attempt to solve the problems of dual loyalty has been to improve our EMR to allow us to better monitor vulnerable groups of patients and their health outcomes. As a primary care doctor, I was ambivalent about the arrival of EMRs in clinic settings because their benefits came with some important downsides. For anyone who has sat with a doctor who was focused on a screen instead of them, these drawbacks are well known. This is even more of an issue in jails, where getting health providers to pay attention to the human being in front of them is a major challenge. But as a human rights tool, I have never encountered anything so powerful. Having an EMR that we could change ourselves allowed us to match variables associated with vulnerable cohorts of patients with other risk factors of the jail setting and with health outcomes we cared about. We took this approach in tracking injuries, including blows to the head. We also took this approach with self-harm. We were able to create standard templates in the EMR that would capture structured data elements about each patient who experienced these important health outcomes, including types of injuries and self-harm acts, as well as clinical severity. We could also capture key information about the jail setting. For self-harm, we could capture type of housing area (solitary confinement, mental health, general population), time of day, and location in the jails. For injuries, we could capture whether the injury was intentional, and if so, who caused the injury—a correction officer or someone else. By capturing the characteristics of the patients, their health outcomes, and the jail setting together, we could then make powerful analyses of these data in the aggregate. In these ways, the EMR has allowed us to change how we collect data to improve individual clinical encounters, but it has also allowed for analysis of the risks of incarceration. We’ve generated numerous reports on these topics, often with the idea that they would be reviewed and acted upon even by people outside the health service. This represents the crux of our human rights work. Some of the risks of incarceration we could address...
ourselves, by improving our provision of care. Others would require outside intervention, including investigation of abuse and neglect and rethinking decisions about who should be incarcerated in the first place.

Candie Hailey’s case and our data reveal the troubling experience of health staff clearing patients for solitary confinement. When jails and prisons seek to place someone in solitary confinement, mental health staff are often asked to certify that they won’t suffer some serious harm as a result of being punished in this manner. This task is different than being able to pull people out who become ill. It essentially asks a health professional to guarantee that an individual can be subjected to punishment in solitary without suffering harm. Health clearance for solitary is not based on any reliable science and violates basic medical ethics principles, because, of course, that patient is supposed to suffer. It’s punishment, after all.\textsuperscript{16} Also, it is unfortunately one of the few correctional practices that continues to be supported by both security officials and some advocates for prisoner’s rights. Security leaders (and city or county law departments) want a medical seal of approval for their punishments, to absolve them from liability for later adverse outcomes. Some lawyers and other advocates for prisoner’s rights also press for this clearance to be part of oversight of solitary, incorrectly thinking that this helps patients. It does not. Because there is no medical science behind this work, health staff cannot predict the future any better than anyone else. Health staff in this role find themselves in the path of the security staff just at the moment when they want to punish. The outcome of this dynamic is predetermined: the more powerful security staff will prevail in most cases, and the health staff will learn to stay out of the way. Advocates and judges who promote this practice then become frustrated with health staff for not using their power to keep patients out of solitary when appropriate, not understanding that consigning health providers into an unscientific and unethical process helps to create this fictional capacity. In general, when we raise this issue with security leaders, oversight bodies, and advocates, it is seen as ethical hand-wringing. The fear of liability for sending the wrong patients into solitary is the primary concern. The nature of the clearance process undermines medical ethics and guts our ability to provide care. And the other side of the balance sheet is blank; the thing everyone wants, a safe approach to solitary confinement, remains mythological. It is one fiction in support of another.
We’ve failed to win the argument and get out of the dirty business of solitary clearance, so we seek to reduce the harm of the process, especially on the line staff and in their interactions with patients. In addition to barring solitary punishment of adolescents and the mentally ill, DOC in NYC also undertook significant reforms to reduce the use of solitary among adults. All of this shrunk the footprint of our clearance and dual loyalty issues. More recently, we have started to shift responsibility from the line staff to leadership for the clearance process, with the goal of keeping the facility staff out of the ethical compromise and keeping them engaged with their patients in a manner that’s true to their training and mission. This also removes the facility staff from being stuck in the heat of the moment, when security staff urgently want a clearance sheet signed and ask health staff to divine the potential health outcomes of solitary. In our higher-level reviews, we rely on data (see chap. 3), and instead of saying that someone is cleared, we record that there is a health risk for everyone who enters solitary and that the patient in question has either the baseline health risk when exposed to solitary or a higher-than-baseline risk. It’s important to remember that clearance is different from surveillance, which is an actual health process. All solitary confinement settings that exist should have health staff present every day to detect patients who are faring poorly for medical or mental health reasons. These patients should be removed, and they should receive all the assessments and care they need. This is a true health intervention, and it does not make the health service part of the decision to punish. The pressures of the security service still bear on the health staff, and patients will surely be motivated to get out of any facilities that cause them harm. In the end, there is no way to balance human rights and solitary confinement. We need to eliminate reliance on solitary as a method of punishment. For correctional health staff, being the stamp of approval for punishment is far more caustic and unscientific than being asked to identify and care for those who need removal from solitary.

Establishing human rights as part of our health mission has revealed how complex a setting we work in. There is no doubt that the issues of dual loyalty, confidentiality, abuse, and neglect are fundamental challenges to the health of incarcerated people. Every correctional health service needs the
support and autonomy to deliver care to patients and also to train staff regarding these issues. Ideally, the correctional health service can discuss and address these issues with the security authority, such as the sheriff or DOC. Many will correctly point out that the health service is always less powerful than (and often employed by) the security service, making a meaningful collaborative approach difficult to achieve. Because the dual loyalty trainings capture feedback, we have learned a great deal from our staff about how to navigate these power imbalances. In the scenario where the patient disputed the cause of his injury, the doctor was able to document the truth of the patient’s injury in the EMR but still avoid a conflict with the correction officers in the moment. This can be tricky when a doctor is seeing a patient in a small cubicle and with an officer standing near or at the entrance to the cubicle. Although it’s bad practice, the officer standing at the ready may be the same person who just fought with the patient, and their animosity can simmer and come to a second boil while the doctor or nurse is trying to deliver care. I have been in the middle of a number of fights between officers and patients, and worry about being harmed is a common concern. Also, the health providers have often been told something about the patient by DOC staff before the patient is ever seen, so there’s often an expectation that the doctor or nurse will treat the patient in a manner in which the officer dictates. I’ve had officers tell me that a patient was faking, or that he or she threw the first punch, or had it coming, along with a number of other comments designed to color the interaction with the patient.

As a result, building out the capacity of our EMR to receive and report sensitive information relating to abuse helped to keep health staff out of adversarial interactions with security staff. The more we can build systems to alert us of key events like broken bones or lacerations and aggregate data for larger systems-level discussions, the more transparent the system is and the less room there is for ignoring problems. Also, reporting on standard metrics like injury and self-harm rates, as well as how reliably our patients are brought to their appointments, can give both oversight bodies and security and health leaders a common set of metrics to track.

These issues are rarely discussed in US correctional health systems, and the fact that human rights and dual loyalty remain basically off-limits topics in most jails and prisons reflects the deep divide between our highest principles and the base reality that Candie Hailey experienced. Staff and patients
alike are thirsty for a more meaningful approach. These trainings were very popular with staff: over 600 health staff completed the online module, and more than 90 percent of them reported that the trainings were helpful and that they wanted more similar opportunities.

There is no doubt that correctional health services can either protect or erode an inmate’s human rights. On most days, for most staff and patients, it isn’t the most critical issue. But like handwashing and infection control, ignoring human rights virtually guarantees that correctional health systems will fail their patients. Virtually every doctor and nurse is required to take yearly infection control training to ensure that they are aware of the widespread prevalence of germs in hospitals and the continual risk of spreading disease to sick patients in their care. These trainings acknowledge the presence of germs and focus on how to reduce their spread and the likelihood that health staff will harm patients through poor infection control practices. Throughout the 5,000 US jails and prisons, dual loyalty and other human rights challenges pose a similar threat, pervasive and more deadly when ignored. Like Ms. Hailey, thousands of correctional health patients manage to get into a cubicle with a doctor, nurse, or social worker, only to find out that their story isn’t believed or that the provider’s mind was made up before they even sat down.

Some of the conditions that Ms. Hailey experienced have improved: I left as a progressive new warden took over in the women’s jail and essentially eliminated solitary confinement for women. We made minor changes to our dual loyalty trainings to meet requirements of the new settlement agreement between NYC and the US Department of Justice around brutality in the jails. Having this training now carry the weight of a DOJ settlement has helped us to establish its credibility with those outside our worldview. Before the DOJ came to NYC, we were the only jail system training our staff on dual loyalty, and our efforts were viewed as interesting and even admirable but not necessary. I think that NYC is still alone in these trainings, but since they are supported by a settlement with the DOJ, they have a higher profile and are more likely to be adopted by other systems that find themselves in trouble and looking for measures to improve health outcomes and reduce brutality. One place outside the NYC jails where this training has taken hold is in the Icahn School of Medicine at Mount Sinai, where students receive dual loyalty training, including correctional health scenarios, under
the leadership of Professor Holly Atkinson. In the NYC jails, we also opened new units for women with serious mental illness that provide higher levels of therapy and support, as well as new crisis intervention teams of health and security staff to respond to confrontations and behavioral problems with the mandate to de-escalate, not escalate. These teams are standard in community policing reforms, and this approach is extremely important to reducing the escalation of frustrations into infractions, assaults, and other bad outcomes in jails. We are just now designing new units that focus on patients with personality disorders, those with profound behavioral problems. Unlike the existing units for patients with psychotic disorders, the patients on these units won’t be expected to have dramatic responses because their behavioral health problems simply don’t respond very well to medicines. These units will require intense work to engage with patients during group and individual therapy, and success will be far from perfect. Many of these patients experience multiple violent interactions with guards each month. The new units will hopefully help them live with less friction with staff and other patients.

In addition to training correctional health staff about human rights, we need to do more to ensure the independence of these health staff. In most jails, correctional health staff actually work for the sheriff, DOC, or a for-profit vendor hired by the security authority. We need to promote alternative models, especially in smaller places that lack the resources of NYC, Chicago, and Dallas. This will be difficult, however, because most community health systems are terrified to become involved in correctional health, and we have yet to scale up any corrections-specific nonprofit providers. In a later chapter I will discuss the prospect of bringing in Medicaid funds to cover some of the jail health care. This funding would support evidence-based care and bring welcome quality oversight that could help the health service to act more independently.