

## NEW PERSPECTIVES: PART I

## Operationalizing a Human Rights Agenda in Correctional Health

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**T**he Bureau of Correctional Health Services of the New York City (NYC) Department of Health and Mental Hygiene is responsible for all aspects of health and mental health care for those incarcerated in the NYC jail system. In 2012, the Bureau adopted a human rights framework as one of the key tenets necessary for the provision of health care in the jail setting. Along with patient safety and population health, we declared human rights to be one of the “triple aims” of correctional health.<sup>1</sup> Although the provision of health care as a fundamental human right is accepted in the language of the United Nations’ “Universal Declaration of Human Rights,” the concept of a right to health care has a more complex history in this country and is not universally accepted. However, it is within the framework of our own laws and constitution that the courts have clearly mandated a right to health care among the incarcerated.<sup>2</sup>

The legal mandate to provide health services to the incarcerated reflects the loss of autonomy that occurs in jail and prison. Incarcerated patients experience a limited ability to seek and participate in their own care. Mechanisms such as intake examinations and daily sick call are designed to identify the needs of each incarcerated patient, but when these services are displaced or interrupted, patients inside jails and prisons cannot reschedule their care as one would in the community. A related concern is that the very nature of correctional settings places a premium on security and relegates medical and mental health services to a secondary level of priority. The pressure exerted on clinical staff and patients by the security needs of these settings has led us to identify human

rights as an essential component to our health mission. Although the concepts and methods of human rights suit themselves very well to correctional health, they remain foreign to most US health systems, especially those within the walls of jails and prisons. One basic approach of human rights—documenting abuse—provides a good example of this disconnect. Human rights workers often document abuse and other concerns with the knowledge that their efforts may not quickly lead to change. Health systems, by comparison, are designed to find and fix all manner of problems—from patient diagnoses to infection control to staffing ratios—in a very expeditious manner. Common features of health systems, such as infection control, quality assurance and improvement, and morbidity and mortality reviews, are all geared to identify and address systems issues related to care with an emphasis on accountability and timeliness. Within correctional health settings, there is an additional barrier to documenting human rights concerns: Health staff commonly are employed by the security authority, such as the department of corrections or sheriff’s office. This arrangement can create a disincentive to report problems, especially those that are difficult to fix. The integration of human rights into our overall mission is an acknowledgement that our health system bears a central responsibility to provide care and document health risks; this is a right that the correctional setting confers to patients.

We have worked to operationalize the human rights framework at several key levels of our health system. At a very high level, we created a quarterly meeting called the Human Rights Collective, where we engage

human rights experts, academics, policymakers, and formerly incarcerated persons to discuss human rights issues in our settings. Topics have included dual loyalty, solitary confinement, racial disparities in care, and human trafficking. These discussions then result in recommendations that are delivered to the Human Rights Quality Improvement Committee (HR-QIC), which is one of several committees that make up our overall quality improvement structure. The HR-QIC is composed of leadership from jail, medical, nursing, mental health, and administrative staff and works to develop new policies, procedures, or trainings.

One instructive example is the problem of “dual loyalty”—the conflict between professional obligations to patients and the interest of a third party, such as the security authority of the jails.<sup>3</sup> In the case of health care in jails and prisons, the conflict between the desires and needs of the patients and of the security authority comes to the surface in clinical interactions almost immediately and universally. Health care staff are routinely asked to mediate between patients and the security authority, such as deciding which patients are authorized to carry a cane, wear their own shoes, or be spared from certain types of restraints. These decisions often put the staff member in conflict with either the patient—their primary loyalty in the healing dyad—or with security staff—colleagues on whom they rely for their safety and security and who also commonly represent their employer.

Even mediating the most mundane dual loyalty disputes leaves staff feeling that they let down one side or the other. Universally choosing the

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side of the patient will lead to conflict with the security staff and may also compromise the security of the facility; however, denying even one patient the medical device or permit that he/she needs can destroy the therapeutic alliance between healer and patient. Furthermore, the medical assessment requires the integration of both objective and subjective factors (i.e. the history of present illness). Such arrangements lead health care staff over time to be distrustful of their patients. Without the ability to rely on the subjective component, the decisions they are forced to make are essentially arbitrary. Dual loyalty also applies in more high-stakes decisions, such as in systems where health care staff have authority to remove patients from solitary confinement or are integrated into the punishment process by “clearing” patients for solitary confinement. Though such arrangements are ostensibly established to protect patients, the repeated exposure to this dual loyalty conflict can be traumatic for health care staff, cause burnout, and lead staff to gradually drift toward a primary loyalty to the security staff rather than to their patients.

Dual loyalty was an early topic of the Human Rights Collective, resulting in a formal assessment of the problem by the HR-QIC. Substantial concerns were documented. In response, a dual loyalty training was implemented for all staff in our system. The goal of this intervention was to increase staff awareness of the phenomenon of dual loyalty and to give them tools to employ in difficult situations. The first component of the training was online and included basic definitions of the dual loyalty concept as well as a presentation of a series of dual loyalty scenar-

<b>Table 1. Human Rights Agenda</b>	
<b>Human Rights Concern</b>	<b>Interventions Employed or Proposed</b>
Dual Loyalty	Training/Education Workflow Changes
Injury/Abuse	Electronic Health Record Flags/Surveillance Anonymous Reporting Data Analysis
Solitary Confinement	Data Analysis
Sexual Assault	Reporting Mechanisms Training/Education Data Analysis
Mass Incarceration/ Patient Confidentiality	Training/Education Physical Plant Changes Workflow Changes

ios with multiple options on how health care staff might respond. Scenarios included the role of health care staff in approving the punishment of patients with solitary confinement, providing condoms to a transgender patient, and witnessing physical abuse of a patient by security staff. Staff were asked to respond to discussion questions on each scenario. The training was recognized as important by more than 90% of participants, with staff requesting additional training on this issue in the future (unpublished data). The answers given by staff during these trainings were compiled and presented in multidisciplinary, small-group discussion sessions led by leadership staff.

In addition to dual loyalty, the HR-QIC has identified a wide range of systems-level interventions that can be applied to key areas of intersection between human rights and health care in the jail setting. One of the most important strategies has been to leverage our system-wide electronic health record (EHR) to assist in surveillance. Finding key data elements that might be flags for vul-

nerable patients and reporting on these data elements has allowed a level of surveillance that was previously impossible.<sup>4</sup> Because injury is such a prevalent problem in our setting and certain patterns of injury may reflect abuse, we implemented flags that allow us to collect data about injuries and patterns of injury to share with our partners in the security authority, including defining the incidence of traumatic brain injury in an incarcerated setting for the first time.<sup>5</sup> Data collection and analysis have also been key strategies for defining the health consequences of solitary confinement, which have led to progress in working with the security authority to establish alternative management strategies for vulnerable populations.<sup>6</sup>

Other strategies include rethinking workflows to relieve dual loyalty pressure points and anonymous reporting of human rights concerns through an e-mail system established specifically for this purpose. Examples of interventions employed and considered appear in Table 1. Future directions include exploring ways in

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which the incarcerated setting influences traditional medical ethics concepts, including patient autonomy, beneficence, informed consent, non-maleficence, and confidentiality.

By leveraging current processes for quality improvement, we have been able to approach human rights concerns with the same rationale and strategy that we use to address patient safety and medical error. The HR-QIC has had success in taking the abstract concept of human rights and operationalizing interventions to address specific areas of concern. In this way we hope to make attention to human rights part of the daily work of providing health care in the NYC jails. We argue that correctional health care leadership must be devoted to this key component of cor-

rectional health in order to adequately serve incarcerated patients.

### References

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