

TPWKY - Special Episode - Homer Venters

EW: Hi, I'm Erin Welsh and this is, this podcast Will Kill You. You are tuning in to the latest episode of the T-P-W-K-Y Book Club series where I chat with authors of popular science and medicine books about their latest work. We have covered some. Books and topics so far this season, from the history of phage therapy to the origins of language, from the exciting science of regenerative medicine to the surprising reality that everything truly seems to be tuberculosis, and we've got more book club episodes on the way. If you'd like to check out the full list of books that we've covered this season and past seasons, as well as get a sneak peek at the ones we've got coming up, head over to our website. This podcast will kill you.com. Under the extras tab, you'll find a link to our bookshop.org affiliate page, which has a bunch of Tpw KY book lists, including one for this book club series. This is a great place to find gift ideas for the book lovers in your life. Seriously, check in on these lists regularly because I'm always updating them. As always, we love hearing from you all about these episodes and about our other episodes, so if you have anything that you'd like to share, reach out through the Contact Us form on our website. Two last things before moving on to the book of the week. First, please rate, review, and subscribe. It really does help us out. And second, you can now find full video versions of most of our newest episodes on YouTube. Make sure you're subscribed to exactly right media's YouTube channel, so you never miss a new episode Drop.

EW: Our modern day public health toolkit to prevent and control the spread of disease is jam packed. We have diagnostic technology. We have medical interventions and treatments. We have epidemiological policies to interrupt the chain of transmission, and we have intricate knowledge about how communicable diseases behave under different conditions. In short. We have the tools to greatly reduce morbidity and mortality from infectious diseases. What we still lack, however, is the will and the resources to apply these tools everywhere they are needed. And one area of great need is our correctional facilities, jails, prisons, immigration detention centers and juvenile detention centers. Places where overcrowded, unsanitary conditions and inadequate medical care allow communicable diseases to spread unchecked. This pervasive neglect will continue to fuel health inequities until healthcare in these settings is reformed. What might meaningful reform look like? The author of this week's book holds the answer in *Outbreak, behind bars, spider Bites, human Rights, and the Unseen Danger to Public Health*. Correctional Health Physician and Epidemiologist, Dr. Homer Venters reveals the systemic issues driving the

rampant spread of disease in correctional facilities. As the former Chief Medical Officer of the New York City Jail system, check out his previous book titled *Life and Death in Rikers Island*, and through his current work as a federal monitor of health services in several jail and prison settings, Dr. Venters has extensive firsthand knowledge of the barriers that prevent adequate medical care to be delivered. To these populations and he has evidence-based solutions. The scope of this problem is massive, and as this administration ramps up its ice, raids and expands federal policing, we can only expect it to grow. This book serves as a powerful and practical overview of the challenges facing healthcare in correctional facilities, and clearly demonstrates the need for a human rights approach to this issue. Before I share this interview with you all, I do wanna mention that both suicide and violence are discussed, so please listen with discretion. Let's take a quick break and then we'll get right into the interview.

EW: Dr. Venters, thank you so much for joining me today.

HV: Uh, thanks for having me. I'm really thrilled to talk about the content and also, uh, as I said, I've, I'm really just fascinated with all the topics you've delved into already.

EW: Oh, thank you. Well, as the former Chief Medical Officer of the New York City Jail System, you have extensive, firsthand experience witnessing the waves that certain diseases in institutional settings such as jails can truly thrive, which is what you explore in your book, *Outbreak Behind Bars*. Can you tell me about the making of this book and when you decided to write it?

HV: Yeah, I really thought about writing it. I was actually gonna, I wrote originally a book on called *Life and Death in Rikers Island* that was about some of the horrible causes of mortality and violence behind bars. But then I was going to write a. Second book about something else. And then when COVID hit, I was the president of a really small nonprofit and I handed that off to people who were probably better at running it than I was. And I just started responding to COVID outbreaks around the country. So for a couple of years I was on the road constantly going from outbreak to outbreak. Different reasons that I would get into the jail. Sometimes I'd be invited in, sometimes I'd be have to force my way in with. Through litigation, but for a couple of years I was really on the road. I went to about maybe 60 or 70 outbreaks. And so as I was going around developing tools for myself to use to understand the adequacy of the COVID response, it really helped me see the broad spectrum of infection control practices and resources and, you know, learning. At Rikers, I learned a lot about one place, and in doing all of these COVID responses, it taught me a lot about some of the common pitfalls, some of the common gaps, and some of

the really successful strategies when it comes to infection control, infection prevention, response, things like that. And so it really became a brainer for me to think as I looked back and in the field work kind of lightened up, uh, for me to think about putting this together in a book.

EW: As you describe in your book, correctional facilities truly really promote the spread of certain diseases for a number of reasons. You know, from things like the architecture or organization of the buildings themselves to the neglect that's often present in these settings. Can you take me through some of the systemic factors that drive disease transmission in these settings?

HV: Sure. And I think, you know, I came across a word actually on your website, uh, ecology, which is really such a great term, which we don't use much in public health in like a lot of public health settings that I've encountered. But it's such a perfect way to encapsulate the intersection between people's health and these outbreaks and their physical surroundings. And so I think most people understand that the close proximity of prisons, jails. Immigration detention, juvenile detention centers that promotes the spread of disease that's communicable. That's, mm-hmm. That makes sense. I think what is not so apparent to a lot of people is that the lack of sanitation, the incredibly filthy unsanitary conditions also promote that spread, uh, when the conditions are even more cramped than normal. So if people are sleeping on floors, touching each other, sleeping in common pens and areas that are never cleaned, that promotes the spread. And then there's this much more hidden set of promoters, of outbreaks. Uh. That include, uh, barriers to medical care for individuals. People can't get to, you know, when they have a new symptom, they can't get to care. Um, barriers to outside health agencies being involved. So the local public health department that might do a great job at a, uh, you know, outbreak at a church or a nursing home might not be involved, uh, behind bars. And then I think there are also. Real barriers in terms of infection control resources. Um, one thing I often find is that I'll get to a jail or prison. Um, I'll get the staffing matrix and there'll be a, a line on there for an infection control nurse or maybe a half of a part-time, uh, of, of part-time, like a half FTE of a infection control nurse. Line is often unfilled. Um, it's a way to kind of save money or not fill a line that some people think isn't important. And there might also be, by the way, an infection control officer who's supposed to have like a, a security middle manager, like a sergeant or a lieutenant who's supposed to spend a quarter or half of their time on infection control. And those lines often are just. Not filled. And so you don't have the people there doing the jobs that we think are important.

EW: Right? And it is really dystopian and disturbing how much of it is just a, a money saving aspect. It's just let's, let's save money. And it's sort of this, you know, ounce of prevention, pound of cure, et cetera. But there are these systemic and structural problems with delivering adequate medical care to those in prisons. People in prisons and other institutional settings accessing medical care. But there are also these issues that you discuss stemming from bias leading some of those who might be in the position to give someone or, or let someone get access to medical care, leading those to downplay or dismiss someone's concerns. What are some of the ways that this neglect or this bias manifests?

HV: Well, I think it starts with just patients who have, uh, symptoms not being believed. So in the Mrs A chapter, I talk about this, I think in actually almost every chapter I talk about this, where people are reporting symptoms that are exactly kind of textbook symptoms that we would want them to report. So we can know either that a new outbreak is afoot or that it's spreading to a new area, or that maybe treatment wasn't complete or effective. But often they're either disbelieved or they're kind of fended off with very rote and ineffective healthcare encounters. Uh, there's something called a sick call encounter where a patient might have to pay to see a nurse. That nurse might just talk to them briefly, might not even do much of a physical exam. They might never see a doctor or a, a nurse practitioner or a physician assistant. They might have to go through that cycle of seeing a sick call nurse over and over and over, not getting any effective diagnosis or treatment. And so those barriers are built into, uh, jails, prisons, immigration, detention centers in many of the outbreaks I've investigated.

EW: So there's the sort of just inherent stance of you really have to fight to have your medical concerns addressed at all.

HV: Yes. And there's a downside to that. I mean, there is, these are paramilitary settings. So unlike, you know, as much as it's difficult to work in a hospital or a clinic, uh, these are places where raising. Alarm or raising concern in a way that makes you stand out from everybody else can bring very swift retaliation, uh, all the way from having losing services, being locked in a cell by herself, put into solitary confinement, beaten, or subject to physical, uh, or sexual abuse. And so those things don't happen all the time to everybody. But that risk of raising your hand and pushing harder than everybody around you to get your point across about. Health issues, uh, there is that risk inherent, uh, because of the, the power and security dynamic.

EW: Mm. And you also talk about how mistrust flows in every direction. Can you say a little bit more about what you mean by that?

HV: Yeah, it's really profound. You know, we talk a lot.

HV: Well, at Rikers we would talk a lot about this problem with dual loyalty, which is when your health staff really aren't working to the benefit of the patients that they're there to take care of. Uh, but the mistrust. It from the patient standpoint, the health service may be involved in punishing them or in withholding care in ways that has really dramatically impacted them. So imagine you're a person who has a mental health crisis, uh, and you get in trouble. You break the rules of the facility, and then health staff say it's okay for you to be punished via solitary confinement. Which is horrible, punishing, torturous experience. There are many ways in which the health staff may be co-opted, uh, in the patient's view as aid to become agents of the security service. So they're not really acting on behalf of the patients. So. You know, fast forward to when an outbreak occurs. You may not feel like those health staff, those nurses, those doctors are really there to help you.

HV: And I think that the current problems around the country with, uh, excessive use of lockdowns, this is when people are locked in a cell or locked in their housing area, and then health staff may come and kinda minister to the unit in very limited fashion. I think it's easy for patients who are locked up to feel like the health staff aren't helping them, and then. From the perspective of the health staff, they may both distrust the patients. They may be afraid of them, but they also may only see them in moments of crisis. Mm-hmm. So in that same lockdown scenario, if the doctor or the nurse can, can rarely get to see their patients, those patients may be in very agitated, upset moods, uh, or frames of mind, very sick. So it doesn't help the dynamic of those two engaging. And then there's the dynamic of the security service. The health staff may both. Be afraid of them and also rely on them for physical protection. So it's a, it's a pretty difficult scenario, even when things operate the way they're supposed to by policies. And obviously it's often the case that they're not operating that way.

EW: Let's take a quick break and when we get back, there's still so much to discuss. Welcome back everyone. I've been chatting with Dr. Homer Venters about his book *Outbreak Behind Bars*, *Spider Bites*, *Human Rights*, and *The Unseen Danger to Public Health*. Let's get back into things. And of course this will affect every aspect of health in these settings, but you know, you discuss certain diseases or types of diseases that have a propensity to spread or to have greater severity in prisons, jails, immigration, detention centers. What are some of those types of diseases that really do thrive in these conditions?

HV: I think there are many, many communicable diseases that thrive in these places for different reasons. So. You know, for places that have a great churn of

lots of people coming in and have lots of overcrowding, especially overcrowding among people who just arrived, you may find housing areas or pens, intake pens where scores of people are sleeping on the floor, touching each other in physical places that are never cleaned, that have fecal material that are completely filthy, dirty, no sanitation, may not have those, people may not have access to bathrooms sometimes, and so that. Dynamic, certainly promotes the spread of both staphylococcal skin infections, anything that's on the skin, scabies, lice, but also, you know, respiratory infections. That's one dynamic. Another is that behind bars, almost every health crisis is met with the patient being thrown in a locked cell. So this sounds insane for people who work in other settings. But you know, the leading cause of death in US jails has for a long time been suicide. Many of those suicides occur when a person has been identified as having some mental health issue, and then they're thrown in a locked cell for what might be called a mental observation.

HV: Um, or they may be in withdrawal or both, right? Withdrawal and, uh, having a mental health crisis. Those people who are thrown into those lock cells for a range of. Real health crises then are often forgotten. And I don't mean forgotten like it may be that a mental health person comes by their cells and says something to them through a locked door a couple times a day. But in the last few years, I've investigated several starvation deaths. Human beings who are in a jail, a fully staffed jail or prison who starved to death in one of these cells. And that happens because people stop caring about, or even thinking about their physical health. And if you, you know. Look at who has died from starvation. You often find that they also have horrible scabies or lys infestations. Um, and so that tendency to take people with a health crisis behind bars and lock them in a cell is another type of very serious infection risk. Infection control problem, because those cells are never gonna, those cells almost never get cleaned, never get effectively. So the next person who come in could. Get the same problem. So there are other dynamics for sure, behind bars, but those are two that I think really stand out. One is the new intake. People crammed together an intake pens, and the other is this kind of people who are sick from a behavioral health standpoint, just being locked in a cell by themselves and forgotten from a physical health standpoint. It

EW: is truly horrifying to to think about how. These problems that are so rampant that clearly many solutions are needed and they're, they're needed at all these different stages, right? They're needed for preventing the spread of a disease in the first place. There's controlling its spread, which is, has a different set of strategies and tools that you need, and then there's reducing morbidity and mortality. What are some of the solutions that you think will help address these issues? I guess practical solutions, and then what are some of the barriers to implementing those solutions?

HV: I think that one of the. Kind of medium term, like it's not the smallest thing, but it's a, it's a pretty decent thing for a facility is to make sure these infection control rules are filled. It's not hard to find, you know, nurses all over this country, millions and millions of nurses know about infection control. So do doctors and PAs, and, and PAs. And so it's not hard to find people who understand the basics of infection control and can find, you know, the weak spots in a facility or things that need to be improved, but when those lines are allowed to go unfilled. Or when somebody who's supposed to be halftime infection control has like three other full-time equivalents of work to do, it's not gonna happen. And same for the security staff. And so I've seen very effective partnerships between the infection control, uh, nursing staff and security staff when they really are, you know, have the resources and time.

HV: I think from my standpoint, most of my work now is as a federal monitor, which means a, a, a federal court will put me in the role of. Tracking and helping to improve healthcare in a prisoner or jail. And that can take years. And so as a federal monitor, it's great because I get to work with a facility, there's a settlement agreement that other people came up with, but then I get to come up with a plan, you know, with the facility and, and, and track it, you know, quarter, hour, quarter. And one of the things that I think is most effective, uh, is building connections with the outside health department outside of jail or a prison. Because we could go to, you know, there are about 7,000 jails, prisons, detention centers of different stripes around the country. It's pretty rare that a local health department is really involved in assessing the adequacy of anything that happens inside those boxes.

EW: Mm-hmm.

HV: And so from my standpoint, infection control and outbreak response is one of the few areas where you do have sometimes some involvement where. Local health department or maybe the state or maybe the CDC might be involved. And so, uh, when I'm a monitor, one of the first things I put on the table is I think it's important for us to all, once we get to the point where we say healthcare has improved, we're all feel like the, the requirements have been met. That one of the things we're. We see on the table as a physical connection, an involvement of the local health department so that when we all walk away from whatever the legal case is, we know that the local health department will be looking, checking these things. And that's really, from my standpoint, really, really important.

EW: I, I'm so curious how you got into this line of work. Like how, how did you find yourself in this position and involved in, in this type of work?

HV: You know, I was a resident in social medicine in Montefiore at Albert Einstein, and I loved that program. I went to that program because I knew that there would be more training in human rights and epidemiology, and I had patients at our clinic in the South Bronx who would tell me these. Really incredible stories about what happened to them in jail, like in Rikers and other places. And I then I started a project as a, a resident. Seeing patients over in the legal, uh, Bronx Defenders, which is like a, a legal aid type organization across the street from us. And I just learned so much. And then I, then my fellowship looked at healthcare for people in immigration detention. Um, and I was also working as an attending in the Bellevue as a program for survivors of torture. And I just, this kind of interplay between, uh, human rights and uh, health I think is so, makes this such a natural area to. To want to be in because you know, in some ways traditional public health and medicine are really antithetical to some of the precepts of human rights in that we're not trained in a hospital to kind of identify problems and not fix them.

EW: You

HV: know, we find a problem and we fix it. Right? And you wouldn't want to be on the hook for not fixing a problem, but in. You know, some of the core principles of human rights involve documenting with your patients or survivors, what's happening to them with the notion that you might not fix that. Um, but to tell the truth, like use your skills as a doctor or a engineer, or whatever it is. And so I. Found that, and we did publish a lot when I was at Rikers about a human rights framework, how we thought it was important to correctional health hasn't really taken off like wildfire, but um, but I find it just really gratifying in terms of this, you know, learning from patients about the reality of their experience using whatever little skills you have and authority you have to kind of like put that on the map and say, this is what they say. It might be consistent or inconsistent with other sources of data. And that kind of. Help get that information into the crucible of, you know, how we should make decisions.

EW: It's an incredibly important, and I think especially with this current administration, which maybe we'll talk a little bit more about later, sort of all of what's happening with ICE raids. But you know, I, I wanna touch on a story that you discuss in your book, which is about tuberculosis, and you kind of highlight tuberculosis as this case study in how. Diseases can be spread through systemic failings. You describe how delivering medical care is a, you know, quote unquote constant exercise in interruptions. What are some of those interruptions when it comes to something like tuberculosis,

HV: tb? You know, I have a great friend slash mentor, uh, Joya Mukerjee, who's partners in health, who I really have learned so much from over the years, but I think she would often describe. And many others before her for zillions of years have described TB as a poor people's disease. And so I think that it is one of the things about tuberculosis is that most jails and prisons in this country. Care about it, like it for a long time has been established as something that you don't want to have happen in your facility. And so most places have a system to check people for active pulmonary t when they come through the front door. And that could, and that involves some, some questions about screening. It involve a PPD, it might involve some other things like a, a interferon gamma test or a, um, chest x-ray. But there's some. Effort then once a year. If you look at most prisons, uh, for people who have been in any state prison system or the federal prison system for, you know, any amount of time, there's supposed to be a check once a year to see do you have new symptoms that might indicate you have pulmonary tb, that kind of yearly check. If it's not a big priority, and this is the case I mentioned in the book, could be swept aside or could be kind of ignored and you know, we know that. Probably five or more percent of people with latent tuberculosis, uh, infection will develop at some point in their lives, uh, pulmonary tb. And so when we stop looking for it, then it obviously is gonna occur because it's a pretty prevalent, uh, situation. And then there's also the component of people not being believed. So people may report, actively report that they have symptoms that are indicative of pulmonary tb. They might not be believed. Um, but I think another part of this is in this country, let's say we have 2 million people about. Incarcerated today or locked up in different places, um, that might represent about 10 million or 8 million incarcerations a year 'cause of the churn. But most of those, those incarcerations are happening in county jails.

EW: Mm.

HV: County jails rarely get into the business of assessing if you have latent tuberculosis infection, are we gonna initiate treatment for you? Mm-hmm. Because the idea is the smaller the circle of things we care about as the health service of a jail, the less we have to do. So if you're a big county and you're, let's say in New York or Chicago or Seattle. Your jail is also part of a local health department or a public hospital service, then you care. Then you wanna know everybody who has latent tuberculosis, infection, and you wanna make sure that they get connected, you know, with their consent to treatment, whether it's in the jail or when they go home. But for most of the. 3000 or so county jails in this country, um, the circle of things they care about is pretty small and it has to do with trying to prevent death for the little time they're in jail. And so you miss that. Um, and I think that it really goes towards this framing of healthcare behind bars is mostly cut away. From the rest of healthcare in this country. And

so the things we say are important about quality, about continuity, everywhere else, uh, kind of evaporate for a lot of people who are locked up.

EW: Let's take a quick break here. We'll be back before you know it.

EW: Welcome back everyone. I'm here chatting with Dr. Homer Venters about his book *Outbreak Behind Bars*. Let's get into some more questions. In addition to tuberculosis. Another infection that you touched on previously is MRSA or methicillin resistant staphylococcus aureus, which is of course spread through close quarters and absolutely thrives. And this is something that, you know, we've known about the hazards of MRSA and the challenges with controlling. Its spread for decades, and yet it continues to cause severe infections in these settings, in jails, prisons, um, immigration detention centers. What are some of the reasons for this? Like how does MRSA manifest differently? Not manifest differently, but sort of play out differently in these settings compared to, you know, community or hospital settings?

HV: Hospitals generally have a pretty strong rubric or structure of infection control. Because hospitals know that, uh, there are bugs of all sorts in hospitals and that when people get infections, new infections, they're more likely to die. They're more likely to get sick. It's very bad for the hospital, uh, for a variety of reasons. Just like you said, we know and have known for decades that these staphylococcal skin infections are a serious problem behind bars. Anytime we find ourselves cramming more people into space than we. No, uh, is a good idea. Anytime we stop doing the basic sanitation, uh, of these places, anytime we start to fall down on things like sick call or letting people get assessed for the care they need, then these are very quick. Response outbreaks. It's not, some of these outbreaks could take a long time to develop, but these can flourish very quickly when these conditions get bad. When access to care is, is denied. I mean, one of the things I usually start with as a monitor is looking at. I'll get all, all of the records of people who reported a, a boil, a blister, a sore on the skin. Mm-hmm. And then I'll go through those records and compare those to who got a culture. And, you know, I'll find often that a great number of people had an open.

HV: Ulcer or sore on their skin that did not get a culture, that lack of adequate diagnosis means that we're undercounting. Likely these are staphylococcal skin infections, and some of them are MRSA. I would add in that, you know, the few times the researchers have looked at colonization rates, uh, colonization rates that. I can think of two or three different studies where they find that the rate of colonization for MRSA behind bars is about 10 times higher than in the community, and it's a little bit of a chicken or the egg. Like think of that solitary

cell I mentioned where somebody was stuck in there for months. If that kind of place doesn't get cleaned or these intake pens don't get cleaned, then you cycle people through and you develop newly colonized people, even if they don't develop an infection. That's an acute, you know, boil or sore.

EW: There's no effort for prevention or control once it's, once it's already there, it just sort of is, you know, manage the best you can. And, and you, you talk about, you touch on this issue of the problems with data and accurate reporting and in terms of reportable diseases, MRSA and, and salmonella do, but they don't. Necessarily, as you said, are accurately reported, but something like heat doesn't count. So there are other ways that morbidity and mortality and, you know, um, disease can manifest in these settings, but may not be accurately reported. What are some of the issues with this?

HV: Both MRSA and heat are interesting because, so MSA, there's a great variation in what's reportable, but most states, if you have what you think is A-M-R-S-A outbreak, you're supposed to report it to the Department of Health. Um, I think that, and my position would be if you have a MSA case in a jail or a prison, somebody needs to go figure out is that an outbreak? Because it's hard to imagine a MRA case in a jail or a prison where you don't have exposure of other people and maybe other cases. So, mm-hmm. My. I think that that's a great example of where if we, you have a local health department with a little savvy who's been in a jail or prison, they would say, geez, we got one case. Then maybe we should go look. I think heat is a great example because, you know, there, there are many jails and prisons and immigration detention centers around the country that have high heat conditions. So over 85 degrees in living spaces and. That's sporadic, right? It might happen some sometimes, and it might go for days. It might go for one day. One of the things that all of these places know is they know who, which patients are heat sensitive. So there's a standard list that's used to identify people who are older, high, BMI anti who are taking antipsychotics, diuretics certain. There's, like in New York City, we had a standard list. Where we looked at everybody coming in the door during, I think maybe from April to October, and we would say, are you heat sensitive? Yes or no? And then on high heat days, it was the job of the health service and the security service to make sure all those people were in air conditioned housing. And most jails and prisons can't do that.

HV: And that is a problem because. First of all, there are a lot of places, and Texas is where a lot of the cases I cite are from. There are a lot of places just have no air conditioning, but even the places that have air conditioning do have air conditioning that breaks down, you know, or there's an emergency or people have you move housing areas, something like that. And so this data about who's

hes sensitive is, is known. But my experience is it's not really utilized by. The health service 'cause nobody's given them the job. Look, these are high heat conditions. You may have to this circumstance or that circumstance, find who's heat sensitive and then go do extra monitoring of them or check on them or make sure they're okay or get them into AC housing. Um, but I think that this is increasingly a problem because you have more facilities in the Midwest. I, I mentioned, you know, that I was in the Northwest and it was like over 115 degrees, 118 degrees or something in Washington. And so it was a good exercise for us to practice. Uh, but this is an increasing problem. And as AC units break, or as people are in places that weren't previously so hot, you know, we need to figure out how to keep people safe.

EW: The things that we've talked about are the ways that disease spreads differently in these settings compared to community settings. And there also seems to be this barrier of just, you know, caring about it, a attention to these issues. And so, you know, the disease spread within correctional facilities really only seem to matter to people when a disease threatens to spill over to the, into the community. But how do infections behind bars also drive community outbreaks? And why is that reality so often either ignored or denied?

HV: Well, that last part is a pretty deep question. I'm not sure I'm have expertise or insights to answer. I think, you know, uh, a colleague, um, Eric Reinhardt, who's a, a physician and an epidemiologist did some great, he and a a team did great, great research around COVID. In the Cook County jails in, in Chicago's County jails driving local outbreaks. So they tabulated, uh, what it looked like, how many cases for a an in jail outbreak were driving out of jail context. Much more than you would expect from just normal community spread. And, and certainly if you. Pick any one of these diseases. Keeping in mind, especially with jails, you have this churn of people going in and out, in and out, in and out, um, or immigration detention where it's like a, a pinball machine where people are going from one place to another, to another, to another. Uh, that obviously can drive transmission from staff and other people around them, uh, whether they're going home or they're just going to a new facility. And so I think that the. The concept is pretty understandable. I don't know why it is hard to figure out a better path, you know, to to pay attention to.

HV: I think that a big part of it is people ultimately don't care. A lot of policymakers just don't have as a high priority these people or their families or their communities. Um. One of the last things we did before I left Rikers is we looked at blows to the head. So most jails and prisons don't report anything about TBI or how often their patients get hit in the head. But what we did is we, because we had an electronic medical record, we built in this like very good tool

for tracking new blows to the head. We then tried to extrapolate to the rest of the country how many. People were accruing new blows to the head, new concussions or more severe traumatic brain injury. And then what that means for their communities and their families as they go home, not just for the short and medium term, TBI, but for CTE to think we have all these poor communities, heavily policed communities where we're. People are going home with having new blows to the head. They also, by the way, have like all these obligations of things they're supposed to do, appointments they're supposed to keep. And so we try to calculate kind of what we, you know, estimate the national rate of this TBI could be. But it goes towards this question you asked, which is, you know, who cares about this? And I think that. Health people and doctors are not gonna fix these social problems. But I do think it's the role of public health agencies to care about them. So if you're a local health department, you should know that people have come home from a jail with scabies and they didn't get the \$40 treatment or uh uh, you know, a second \$40 treatment that they needed 'cause it was ineffective in the jail. Or you should know that they came home with these problems because these do and should matter for you as a public health authority.

EW: And I think of what. Rolls into this too, is resources and just the investment cost upfront. And you know, the, the for-profit prison system is dystopian and horrific for a num, a myriad of reasons, endless reasons. And one of those reasons that you discuss in your book is that there's often or sometimes a policy of withholding medical care to save on expenses. How does this approach lead to just. Overall higher death and disability, especially from treatable conditions.

HV: Well, I think it, it goes towards this question of like, how narrowly have you drawn this circle about health things that you care about inside? So, you know, a good example. Is gonorrhea, chlamydia, diagnosis and treatment. So we know that, uh, if you test males for gonorrhea and chlamydia who are coming into jails who are asymptomatic, we know that that's not just effective for them personally, but it's also effective for their partners, their sexual partners when they go out. And so that. Makes very good sense from a cost effectiveness and also a kind of a public health framework for reducing high risk pregnancies, for instance, for, you know, transmission of gonorrhea chlamydia. I think though that the sanity or the good evidence behind these ideas isn't hard to. Represent. I think it just shows kind of the relative weakness of public health in our country, especially now that we know we have good strategies for effective treatment. We know that putting people behind bars who have a mental health crisis or behavioral health crisis or of substance use issues isn't an effective way to treat their substance use or their mental health problems. But there is, I don't think it's just that there are champions of the policies that are bad for public health. It's

that there are. There is a long list of people who will make a lot of money off of those policies being implemented in a way that causes harm.

EW: One of the, the things that you discuss and, and one of the biggest sources of harm of course, is the COVID pandemic, and you, you write about, um, ones in specific, the Farmville Super Spreader event and sort of the. Bureaucratic apathy that really fanned the flames of this virus. Can you take me through this event briefly? Just, you know, how it began, how it worsened, the, some of the errors that were made, and hopefully any lessons that we have learned from that.

HV: Yeah, I don't, the, again, you've, you finished your question with the hardest Yeah. Most sobering part, which is lessons learned. Geez. I think that, you know, when I wrote the book, I was worried that the Farmville chapter would seem. Fantastic. Or over the top the story of what I, I kind of knew happened and the reporting that people, not me, but others did, but now it doesn't seem so fantastic. Right. But the problem was COVID was in full swing, it was the summer of 2020. The CDC had already given very good guidance about. Basic steps to prevent COVID in detention setting. So this was the CD. C had come out with specific guidance for what to do and not to do behind bars. And two of the things were don't move people around. Uh, certainly don't move them from places with COVID to place without COVID. And when they get to the new place, they're going to take all these steps to make sure that they don't have COVID before you put them into the main kind of area with everybody else. Those are two things actually that were happening at. Farmville. So Farmville's a for-profit detention center that was, you know, an ice detention center. But then for reasons that weren't clear to me or I didn't know about, when I did the inspection, people were moved in the summer from three. ICE facilities that had current or very recent COVID cases, two in Arizona, one down in Florida. 74 people moved into the Farmville Detention Center, and this place had never received 74. I'm not sure they had really received the seven or eight very often, but certainly they'd never gotten this kind of big group of people before they tried to stop it. Steamrolled by, you know, ice authorities. And not only were all these people forced upon them, but then their standard approach, which had been very effective up to that point, which was to keep people offsite for 14 days in a separate building for their intake quarantine that also was steamrolled.

HV: So they said, no, you have to go right into, let's push that. That process. So these two things the CDC had said you should do, which is not moving people from places with COVID into places without COVID. This kind of 14 day quarantine that obviously was pushed aside and within days people had COVID

symptoms and they went from zero COVID to about 90% of the people in this facility getting COVID, including a man from Canada who died from COVID and his family. I put in the book. Heartbreakingly had pleaded to let him just come home to Canada. They were gonna set up a special place for him in their house where he could do an actual intake quarantine in the house. They, you know, made changes and he's the, the gentleman who died. But I think that what came out afterwards, this wasn't part of my work, but what the Washington Post reported was that this was kind of a crass effort to get ice and federal agents moved from one part of the country to another part of the country, and that there were apparently some federal laws or regulations about you couldn't just move them around, and so somebody had genned up this idea that, well, we'll move these, all these people, and then with them move these federal agents so that they can be in the DC area to put down the Black Lives Matter protest. That's the reporting of the Washington Post. You know, what I saw was just the outbreak side of this, which was this place had this pretty standard approach. It was pushed aside and then, you know, COVID was everywhere in the facility.

EW: And there was really this ultimately kind of this lack of accountability.

HV: I think there are two important principles that you need both of. One is, uh, transparency and the other is accountability. And so, and this is again, where I think the human rights framing is very effective, although you could find this in community health too. But the transparency about what's the truth of what happened, what actually occurred was. Hard to understand, but we eventually got there. The accountability, which is, well, who is punished? Who gets, who gets in trouble? Who pays for this? I'm not sure. I think that, you know, for, there was a lawsuit. I was there because there was litigation and so I was an expert for people, family members I think, and others who had. Brought this suit. Um, and for a while the facility was limited in how many people they could have in the building by the courts, but I think that it goes towards this much bigger issue. You know, if a hospital or a dialysis clinic screws up in a way that really harms people, um, they often will lose their ability to either function. Right. If a transplant team or a central line infections, whatever, they may lose their license. The State Department of Health or um, CMS, there are real consequences for health systems that screw up in a way that's, that's avoidable and that hurts people. It, this is almost never the case behind bars, even though these are big health systems, and it really goes to the fact that. The structures that do that important job, not just to the transparency, but the accountability. They're pretty much AWOL when it comes to healthcare behind bars.

EW: Mm-hmm. And you discuss in your book, and you have mentioned that you carry out inspections at, you know, at these different settings in jails and prisons. What are you looking for with these inspections and, and why is an in-person inspection so critical compared to like a video inspection, for example?

HV: Another thing I've learned in human rights is there's always a legal context for what you're doing. So you may not, if you find yourself in a place doing something, um, you really need to understand what's the context for what you, what got you there. And so for me, you know, when I go to a jail or prison, it may be. That me being there, if I'm there, is a monitor where every, like a, a court or the state of whatever, a a, a governor's office or somebody has asked me to go there, then I'm able to kind of go pretty broadly and look in all the nooks and crannies that I need to if I'm there. It's part of litigation. There may have been a very serious. About either keeping me outta the facility and then if I am ultimately able to go in limiting my ability, who I can talk to, what I can do, what I can look at. And so from my standpoint, it's important to understand at the outset what am I there to do. So if it's A-C-O-V-I-D outbreak. I wanna know kind of some basic questions about what are they doing to prevent COVID coming in? Mm-hmm. What are they doing to diagnose and treat people once COVID is inside and what are they doing to protect high risk people? So there are certain physical places I'll want to go, data I'll wanna review, but probably the most, one of the most essential tools is confidential interviews with people who are there.

HV: Those people sometimes take a risk in talking to an outside inspector, uh, because it's knowable, right? It's known who is talking to this outsider and they're, I wouldn't say every time, but I often hear from people that they were warned or threatened before they speak with me or speak with somebody else. But, um, those confidential interviews are really. Critical because it's, you know, it's as if you're walking into a hospital and you don't know how the hospital works or what floor anything's on or where, you know, so those confidential interviews for me are important for the inspection, but they're also important for, you know, what documents do I ask for, or what parts of medical records do I look at.

EW: I wanna touch on, you know, something that we've kind of circled around a bit here and there, and that is this astronomical rise in ICE raids and the number of people that are being put in or moved around these immigration detention centers with this current administration and. In your book, you discuss this horrifying story from 2019 about this 16-year-old boy who was diagnosed with influenza and died in a holding cell after being detained by border Patrol. And I was curious to hear your thoughts on, you know, what do you see

happening and how much or will, will we actually hear about or learn about these things as they're happening versus in the future

HV: in the narrow frame of outbreaks?

HV: I worry a lot about people having infections or communicable diseases that they can spread to each other. One of the problems at Farmville is the basic infection control measures that were in place. Mm-hmm. That ICE said, let's do this. Those got pushed aside just so you could cram more people into this box. I think that that approach, I'm concerned, is much more widespread now if people are being put into a system in places that aren't. Used, like if they're being, for instance, put into offices or if they're put into gymnasiums, if they're been put into these places and they're not being screened for, uh, all the basic kind of health issues, including, you know, signs and symptoms of infections when they come in, then it not only increases their risk of morbidity and mortality, but it also actively, uh, dramatically increases the risk of spread of all these problems. I think that, you know. The problem sometimes with assessing. Morbidity and mortality for people in immigration detention is that many of them end up somewhere else. They get off a plane or a bus or somewhere in another country, so we don't know what happened to them. So if a person, you know, was just about to start dialysis and then they get off the plane in a place that where they're never gonna get dialysis, we don't know that they're gonna die of renal failure, but they may the same goes for, you know, infection for people that have any kind of. Communicable disease. So I think that my experience is that when you jam and cram more humans into these tight spaces and move them around, uh, if you also at the same time push aside your basic infection control and medical screening processes, uh, which was the case in Farmville, then you really create a much higher likelihood of the spread of communicable disease for them, but also for the staff who are, you know, doing all these. Transportation and, and, and interacting with people.

EW: We have touched on so many different issues and at, at every, every level from, you know, individual bias to these structural problems, to these like systemic issues that are pervasive, so pervasive in these settings, and it really. It does feel in some ways, almost like this massive, un insurmountable problem. But I'd like to end our conversation with just sort of talking about what you might see as a path forward. Like I know this is another maybe difficult question, but like what are the immediate steps that can be taken? And I know you touched on some of them, but how do we ultimately overcome. The apathy and disregard for human rights, which maybe is again the, the deep philosophical question that's really challenging to answer.

HV: I mean, it is. I don't, it is a kind of existential. Problem or question. But I do think that having a little bit of humility about our ability, like in epidemiology and medicine and public health, most of the world is not in those domains, but we do have local health departments and state health departments, and in some circumstances we can hold them to account to say, you need to worry about these things. And the fact that we're losing right now, the fact that we're, you know, resources are being stripped away. I understand that it's. Horrible, painful process, but I do think that it's important as a principle to establish or to keep circling back to, you know, if you're a health department, you have to care about the health of the most vulnerable people. The people who have, uh, conditions that we want diagnose and treat, and that shouldn't and can't stop when they're behind the bars of a jail or a prison, or an ice detention center. And so as a monitor. In very few places, but one of the things I've been able to push for is to get a local health department to build up some resources to do that, and I think that that won't fix some of the problems. There are inherent. Health risks of incarceration. So this is kind of your, where I love this, this term, you know, the ecology of epidemics. But people should know that who are in the health departments, they should understand that. And they should be, they should have on their radar and their responsibility list being involved in those risks and being involved in those places. And so I think that anywhere that I'm involved now and recently and for the rest of my career, it will be how can we get the health. Public health experts on the hook for looking into these places.

EW: Dr. Venters, this has been just such an insightful and really important conversation and I really appreciate you taking the time to chat with me today.

HV: Thank you so much. It was really great to meet you to like, learn about your podcast and the other fantastic episodes you've done. So thank you.

EW: A big thank you again to Dr. Homer Venters for taking the time to chat with me. This is such a crucial topic, especially with the current political climate. If you would like to learn more about the topics featured on this episode, check out our website. Thispodcastwillkillyou.com. Where I'll post a link to where you can find outbreak, behind bars, spider bites, human rights, and the unseen danger to public health, as well as a link to Dr. Venter's website where you can find his other great work like his other book, *Life and Death in Rikers Island*. And don't forget. You can check out our website for all sorts of other cool things, including but not limited to transcripts, quarantining and placebo reader recipes, show notes and references for all of our episodes. Links to merch, our bookshop.org affiliate page, our good reads list, a firsthand account form and music. By blood mobile. Speaking of which, thank you to Blood Mobile for providing the music for this episode and all of our episodes.

Thank you to Lianna Squillache and Tom Breyfogle for our audio mixing. And thanks to you listeners for listening. I hope you liked this episode and our loving being part of the T-P-W-K-Y Book Club, a special thank you as always to our fantastic patrons. We appreciate your support so very much. Well, until next time, keep washing those hands.