Ending Life

Incarceration, Health, and Institutional Epistemic Injustice

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I first began thinking seriously about the health needs of people who are incarcerated when I was training to teach as part of the Inside-Out Prison Exchange Program in 2011. More than half of our training took place inside Ryan Correctional Institution, a men's level 2-security prison in Detroit, Michigan. My trainers/mentors were seventeen incarcerated men who were incarcerated. Most of my trainers were in their 30s and 40s and appeared to be in good health. However, two of my trainers, Dee X and Kenneth, were in their 60s. Although they appeared to be in good health in my initial interactions with them, after spending 35 training hours in their company, I learned that they had significant and life-threatening illnesses. Dee X was experiencing kidney failure and had been receiving regular dialysis treatments for 30 years. Kenneth had diabetes and had contracted Hepatitis C from contaminated insulin needles that the state prison system purchased at low cost. Both of these men had served significant time in prison. Dee X has been incarcerated since 1988, and Kenneth has been in prison since 1977. When I last spoke with Kenneth he was hoping that he was going to be granted a medical commutation so that he could go home to be cared for by his daughter who is a physician. I've since learned through my contacts that Kenneth has been moved to another facility for either life extension or a medical commutation of his sentence. Like many people with late stage Hepatitis C he was not just experiencing the physical symptoms of the disease, he was both also experiencing a mental decline that was more stressful for him than the physical concerns and also left him even more vulnerable in prison where mental weakness is preyed upon even more than physical weakness. Dee X remained at Ryan Correctional, which was renamed Detroit Reentry Center, for medical care and is doing as well as can be expected given his condition. Both of these men are critically ill from their diseases. Unless they die from one of the other numerous causes of death more likely to afflict people who are incarcerated, such as suicide or stabbing, they will likely die from these illnesses and their complications.

The questions those of us on the outside—lay people, philosophers, social justice advocates, policy makers, and physicians—should ask ourselves are numerous and complex. Many of them bump up against what we take to be common sense knowledge and reflect our misunderstandings of the health, health needs, and health care of people in the carceral system. Because people who are incarcerated live behind walls that intentionally make their daily lives and, thus, their long and short-term health, invisible to people on the outside, we are ignorant of the health status of people in the carceral system. The knowledge that we have about the health needs and care of people who are incarcerated is produced in a way that silences their voices, hides their bodies, and obscures the stories of their lives. I would have remained ignorant of the health needs of people who are incarcerated if I had not been teaching in prisons.

I begin this paper by giving some background data on incarceration, aging, and health. I then move on to explain an important way in which institutional epistemic injustice is imposed on people and embodied. From there I analyze the effects of this embodied epistemic state on incarcerated people and those who are responsible for caring for them to show how this embodied concept of institutional epistemic injustice can help us understand

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the health and healthcare needs of people who are aging in the US carceral system.[1]

Aging in Prison: The Data

It is tempting to think that there is nothing unique about aging in prison, that aging is merely a biological process. But aging is also a social process that is mediated by the circumstances in which we live. In the 2016 report "The Impact of an Aging Inmate Population on the Federal Bureau of Prisons," issued by the Office of Inspector General of the US Department of Justice, people who are incarcerated are considered "aging inmates" at 50 years of age.[2] The standard among most researchers for an "elderly inmate" is also 50 years of age or older, because people who are incarcerated age 10-15 years faster than people who are not incarcerated. There is significant consensus among researchers and state and federal institutions regarding the accelerated aging of inmates dating back to 1982 categorizing elderly inmates at 50 or 55 years of age.[3]

Of the 1,508,636 people in federal and state prisons in 2014, 280,606 were 50 years of age or older.[4] This represents at 13.8% increase from the 2010 number of 246,600. At the federal level, the Bureau of Prisons states that between 2009 and 2013 there was a 25% increase in inmates 50 years or older, while the population of inmates 29 and younger decreased by 16%.[5] Fifteen US states have experienced a 40-50% increase in their percentage of inmates who are 55 years or older.[6] 42% of elderly prisoners are white, 33% Black, and 15% Hispanic, but Black and Hispanic inmates are overrepresented in the elderly prison population. This mirrors the general data regarding mass incarceration of Blacks and Latinos. Women make up 6.7% of the federal and state prison population, but the rate at which women are incarcerated is "increasing by an average annual rate of 3.4 percent."[7] Of the 280,606 inmates who were 50 years of age or older 15,509 of them are female.[8]

There are several reasons for the increasing number of elderly people who are incarcerated. Much of the increase has to do the tough-on-crime policies that date back to the 1980s, with mandatory minimum sentences, longer convictions, and "three strikes and you're out" policies.[9] People are serving long sentences in prison and thus growing old in prison. Kenneth, for example, has been in prison for 39 years, Dee X for 28. The Bureau of Justice Statistics 2016 report states that "Forty percent of state prisoners age 55 or older on December 31, 2013, had been imprisoned for at least 10 years, compared to 9% in 1993."[10] Furthermore, more people over the age of 55 are being arrested. Between 2003 and 2013 there was a 63% increase in arrests of people 55 or older.[11] Much of this has to do with an increase in arrests of drug offenses, which increased by 375% for those 55 or older.[12] In the US we criminalize mental illness, and mental illness can result in behaviors that lead to incarceration. Substance abuse and arrests for drug offences, for example, are often the result of mental illness. For incarcerated people 55 or older, 39.6% at the state level have a history of mental health problems and 36.1% of those at the federal level do.[13] 73.1% of women incarcerated at the state level and 61.2% of women at the federal have a history of mental health problems, whereas 55.0% of men at the state level and 43.6% men at the federal level have a history of mental health problems.[14] Thus gender represents a significant difference here, one that can be partly explained by the amount of sexual and physical violence that women who are incarcerated experience prior to and during incarceration.

Like people who are marginalized on the outside,[15] the health of people who are incarcerated is complex and compromised by the oppression they may have experienced outside of prison and the oppression they experience in-

1. This paper is part of a larger manuscript length and multi-article based project that engages the multiple ways in which people who are incarcerated experience embodied institutional epistemic injustice. In a longer version of this project I work to take up a more thoroughly intersectional approach, engaging marginal identities, such as gender, sexual identity, race, ethnicity, class, trans identity, ability/disability, and how these shape health and end of life issues for the diversity of people who incarcerated. This project includes analyses of women's gynecological and obstetric care in prisons, specifically the forced sterilization of women who are incarcerated, the high rates of untreated sexually transmitted infections, and the shackling of women while in labor; physical and mental health trauma experienced by transgendered people in the carceral system, especially the high rate of prison sexual violence and suicide; the intersection of oppression and marginality via race, ethnicity, gender, sexuality, sexual identity, economic class, ability/disability on aging in US prisons; the high rates of prison sexual violence on the health of women and its relationship to women's high rate of chronic pain and mental illness; healthcare for returning citizens, medical commutation of sentences, and the role of prison hospice care.

2. Office of the Inspector General, "The Impact of an Aging Inmate Population on the Federal Bureau of Prisons" (Washington, DC: US Department of Justice, Revised 2016), 10.

3. One challenge with data assessing for projects such as mine is that although most institutions use 50 years of age as the mark for an elderly inmate, some use 55. However, the same institutions will sometimes use data categories such as 45-54 and 55-64 in one document and 40-49 or 50-59 in another. This lack of standardization is curious and unfortunate, but one can still see trends in data related to aging even with some of this muddiness of data.

4. Office of the Inspector General, "The Impact of an Aging Inmate Population on the Federal Bureau of Prisons" (Washington, DC: US Department of Justice, Revised 2016), i.

5. Ibid.

6. Christine Vestal, "For Aging Inmates, Care Outside Prison Walls," *Research and Analysis*, *The Pew Charitable Trust*, August 12, 2014, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2014/08/12/for-aging-inmates-care-outside-prison-walls. Note that this age range does not include people between the ages of 50-54, who are included in the federal statistics.

7. Bureau of Justice Statistics, "U.S. Correctional Population Declined by Less than 1 percent for the Second Consecutive Year," December 19, 2014, https://www.bjs.gov/content/pub/press/cpus13pr.cfm.

8. Office of the Inspector General, "Impact," i. The last unique data set the Bureau of Justice Statistics published on women was in 2000. It is thus challenging to get specific data on women from the US Department of Justice.

9. Samuel K. Roberts, "Aging in Prison: Reducing Elder Incarceration and Promoting Public Safety," Center for Justice, Columbia University, November, 2015, xiii.

10. Ann E. Carson and William J. Sabol, "Aging of the State Prison Population, 1993-2013," Bureau of Justice Statistics (Washington, DC: US Department of Justice, 2016), 1.

11. Carson and Sabol, "Aging," 17.

12. Ibid.

13. Doris J. James and Lauren E. Glaze, "Mental Health Problems of Prison and Jail Inmates," Bureau of Justice Statistics (Washington, DC: US Department of Justice, 2006), 4.

14. James and Glaze "Mental Health Problems," 4.

15. See Nancy McHugh, *The Limits of Knowing* (Albany: State University of New York Press, 2015).

side of prison. A prior history of substance abuse,[16] tobacco use,[17] sexual violence and other forms of physical violence, living in poverty, living in a violent neighborhood, being under-employed or unemployed,[18] and poor health care prior to incarceration[19] all contribute to the accelerated aging of people who are incarcerated. The stress of life in prison, including the threat and reality of sexual and other forms of physical violence, emotional manipulation, fear of dying in prison, uncertainty about release dates, isolation from family and friends, solitary confinement, difficulties in navigating the prison and one's cell because of physical challenges, such as wheel chair use, inability to participate in prison programming because of age and/or medical status, and a feeling of lack of purpose are experiences that contribute to the accelerated aging of people who are incarcerated.

People who are incarcerated in the US represent 25% of the HIV infected population, with the progression to AIDs four times faster than in the general population.[20] End stage liver disease mortality is three times higher among incarcerated people compared to that of the general population.[21] 33% of people in the US with hepatitis C are incarcerated, and so are 40% of people with active tuberculosis.[22] Incarcerated people who are 50 years or older have an average of three chronic diseases,[23] and they are much more likely to have diabetes, hypertension, and pulmonary disease than younger people who are incarcerated and people 50 and older people living outside of prison.[24] Approximately "70% of inmates aged 50 years or older have a physical limitation" that affects their ability to function with daily life activities in prison.[25] Researchers and clinicians refer to these as Activities of Daily Living (ADLs), which include being able to feed oneself, bathe, and groom oneself. In a study of elderly women incarcerated in California, 69% of them had at least one Prison Activities of Daily Life (PADL) impairment.[26] PADLs include the ability "to drop to the floor for alarms, stand for count, get to meals, hear orders, and climb onto the top bunk."[27] To provide some context for this, "29% of elderly women in this study were assigned to a top bunk."[28] ADL and PADL impairments are associated with increasingly poor health and adverse prison experiences, including increased victimization through physical violence, increased number of falls, and increased depression.[29] Thus we see a rapidly aging, ill, and vulnerable group of people who are incarcerated, much of which can be contributed to oppressive conditions on the outside and inside of prison.

An Embodied Account of Institutional Epistemic Injustice

Work in epistemic[30] injustice has provided a critical way for elucidating the experiences of people who are oppressed and marginalized. Charles Mills in his book *The Racial Contract* (1997) and Marilyn Frye in her collection of essays, *The Politics of Reality* (1983) set the stage for understanding the connection between dominant epistemic systems and practices and oppression. This work has been picked up by numerous feminist and critical race theorists and has continued to provide a locus for strategic and critical conversations about epistemic oppression and epistemic resistance. Mills's work in epistemology of ignorance brought to bear the ways in which ignorance becomes systemic and embedded in dominant social systems, such that it is "psychologically and socially functional" even though it is "cognitively dysfunctional."[31] In doing so these ignorant epistemic systems replicate and normalize systems of oppression, such that they continue to pass for the truth even though they are instead dominant fictions.

Miranda Fricker's (2009, 2012) work and Elizabeth Anderson's (2012) critiques of Fricker's work have provided a framework and language for thinking about how this embedded and system epistemic ignorance is a property

16. See Office of the Inspector General, "Impact."

17. See Diane K. Duin and Mary Helen McSweeny-Feld, "The Aging Male Inmate: Long-term Care Service Needs and Resulting Policy Implications," *The Journal of Pastoral Counseling* 40 (2005): 97-106.

18. For violence, poverty, and employment information, see Tina Maschi et al., "Trauma, Stress, Grief, Loss, and Separation among Older Adults in Prison: The Protective Role of Coping Resources on Physical and Mental Well-being," *Journal of Crime and Justice* (2013), https://doi.org/10.1080/0735648X.2013.808853.

19. See Office of the Inspector General, "Impact."

20. Jeanette Y. Wick and Guido R. Zanni, "Challenges in Caring for Aging Inmates," *The Consultant Pharmacist* 24, no. 6 (2009), 430.

21. Wick and Zanni, "Challenges," 430.

22. Ibid.

23. See R. V. Rikard and E. Rosenberg, "Aging Inmates: A Convergence of Trends in the American Criminal Justice System," *Journal of Correctional Health Care* 13, no. 3 (2007).

24. See Ingrid Binswanger et al., "Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared with the General Population," *Journal of Epidemiology and Community Health* 63, no. 11 (November 2009): 912-19.

25. Wick and Zanni, "Challenges," 430.

26. See Brie Williams et al., "Being Old and Doing Time: Functional Impairment and Adverse Experience of Geriatric Female Prisoners," *Journal of American Geriatrics Society* 54, no. 4 (2006): 702-707.

27. Williams et al., "Being Old," 702.

28. Ibid.

29. See Williams et al., "Being Old."

30. "Epistemic" is a term used to describe knowledge or a state of knowing. Thus, "epistemic injustice" is an injustice that relates to a person's state of knowing. Miranda Fricker defines epistemic injustice as "a harm to one's capacity as a knower." In Fricker, *Epistemic Justice*, 1.

31. Charles Mills, *The Racial Contract* (Ithaca, NY: Cornell University Press, 1997), 18.

and practice that can be ascribed to institutions, referring to it as institutional epistemic injustice. Fricker argues that just as individuals can have epistemic virtues and vices,[32] institutions have collective epistemic virtues (e.g., trustworthiness) and vices (e.g., negligence or carelessness). Anderson expands upon this idea to consider the ways in which testimonial epistemic injustice, an injustice that questions one's capacity as an epistemic agent, can have structural[33] institutional origins in educational, judicial, political, and medical institutions, and thus needs structural remedies to correct for institutional epistemic injustice. Testimonially just institutions, Anderson argues, are those in which members of the institution "jointly commit themselves to operating according to institutionalized principles that are designed to achieve testimonial justice, such as giving hearers enough time to make unbiased assessments."[34] Institutions that operate in a testimonially unjust manner are those that perpetuate structural "group-based credibility deficits: differential markers of credibility; ethnocentrism; and 'the shared reality bias,'"[35] even though when analyzed from the level of an individual epistemic agent, there was no individual epistemic failing. For these institutions to operate in an epistemically just manner, they need to be structurally reconstructed according to principles and practices that promote epistemic virtues and epistemic justice.[36]

Fricker's and Anderson's accounts provide insight into the structural deficiencies of and the structural remedies for institutional epistemic injustice, but what we also need is an embodied account of institutional epistemic injustice if we want to get at the pernicious effects of it on the bodies and lives of people who exist under oppressive institutional structures. Institutional epistemic injustice is an activity, a form of structural violence,[37] not just a structural deficiency, which imprints itself on the lives of those inhabiting institutional space—such that they come to epistemically and physically embody the institutionalized state. Furthermore, because of their physical structure, some institutions, such as prisons, literally preclude people living outside of these oppressive structures to see inside. Their very physicality presents an epistemic barrier to those of us on the outside from knowing what happens on the inside. Thus their accounts obscure the ways in which institutional epistemic injustice shuts down the ability of individuals to think, act, and live well within their structures, how those structures literally reshape the bodies and minds within them, and how they create physical barriers pierced only by conduits of ignorance transmitting misinformation to those of us on the outside. Fricker's and Anderson's accounts can't illuminate these injustices, in part, because their theorizing about institutional epistemic injustice has been abstract and about institutions in general. Looking at specific institutions and how they function reveals the damaging effects of epistemic institutional injustice. As I develop an embodied view of institutional epistemic injustice I am employing arguments made by Foucault in *Discipline and Punish* (1977). I am also building upon arguments made by the LoCI-Wittenberg University Writing Group (the prison writing group of which I am a member) in our article "An Epistemology of Incarceration" (2016), José Medina's work in *Epistemology of Resistance* (2013), and Lisa Guenther's work in *Solitary Confinement* (2013).

Most people who are incarcerated experience epistemic injustice. As one member of the LoCI-Wittenberg University Writing Group stated: "There is a psychology to doing time."[38] In other words, an inmate must reshape his or her cognitive structure and practices in order to survive prison. On the surface this may not appear to be an epistemic injustice per se. On the one hand it could simply indicate what it takes to survive well in prison, which means developing a particular type of heightened subversive lucidity, which the group refers to as "carceral consciousness" in spite of or in opposition to the epistemic injustice they experience in prison. On the other hand, the

32. José Medina is especially clear in his discussion of epistemic virtues and vices. "Epistemic virtues" are habits that enhance one's ability to know well. Examples of key epistemic virtues are diligence, curiosity, humility, and open-mindedness. "Epistemic vices" are those habits that inhibit one's ability to know well, such as closed-mindedness, arrogance, and laziness. See José Medina, *The Epistemology of Resistance* (New York: Oxford University Press, 2013).

33. See Elizabeth Anderson, "Epistemic Justice as a Virtue of Social Institutions," *Social Epistemology* 26, no. 2 (2012): 169. To describe something as a "structural" problem means to say that the fundamental way that something is set up itself generates injustices. For example, if one views poverty to be a significant problem in the US that arises out of the US economic system, then this would be pointing to a problem with how the US economic system structures benefits, losses, opportunities, etc. Recommended "structural remedies" could range from minor adjustments, such as affirmative action policies or living wage laws, to major adjustments, such as a significant overhaul of capitalism, such as Karl Marx vehemently recommended.

34. Anderson, "Epistemic Justice," 169.

35. Ibid.

36. Ibid.

37. Structural violence is a termed originated by Johan Gatlung, which is now used widely in health justice to indicate how social inequalities can inflict poor health outcomes on marginalized communities. Gatlung describes structural violence thus: "There may not be any person who directly harms another person in the structure. The violence is built into the structure and shows up as unequal power and consequently as unequal life chances." In Johan Gatlung, "Violence, Peace and Peace Research," *Journal of Peace Research* 6, no. 3 (1969), 171.

38. LoCI-Wittenberg University Writing Group, "An Epistemology of Incarceration: Constructing Knowledge on the Inside," *philoSOPHIA* 6, no. 1 (2016), 9.

idea that there is a psychology to doing time also indicates that regardless of whether one serves their time well or not, one is cognitively reshaped by serving time. The same member of our group also stated, "No one can do a certain amount of time and not be damaged psychologically."[39] Our writing group referred to the negative understanding of this cognitive reshaping as being "institutionalized" and argued that it is much more pervasive in prison than its positive counterpart "carceral consciousness," which requires a significant amount of intentionality to achieve. An institution like prison is a bureaucratic, social, and physical structure with these structures functioning in a synergistic way. The physical and bureaucratic structures of the prison shape a social structure in the prison, which in turn shapes bureaucratic physical structures in a frequently reactionary manner. For example, one common thing that happens in prison is known as the "shakedown." The shakedown consists of correctional officers coming through the housing units pulling apart cots, flipping mattresses, and pulling everything out of a locker. A shakedown can happen to just one person, a whole dorm, or the whole prison. Anything from a search for contraband, such as drugs or weapons, or a guard's decision that an inmate has not made her or his bed sufficiently well or kept a tidy enough bunk space can result in a shakedown. In other words, a shakedown can be rather random and unexpected. Just as these institutional structures operate synergistically, they operate *on* the people that are in the institution. As one of my inside students stated in his final paper for class, prison is the epitome of Pierre Bourdieu's habitus, it is a fully structuring, structured, structure; in other words, it is a fully institutionalizing institution. Most people who are incarcerated find the shakedown to be dehumanizing, but for older people the physical stress of having to get their bunks back in order quickly, to get down on the floor quickly regardless of whether they are in a wheel chair or using a walker can be physically stressful or dangerous. For people with mental health problems who may need order and consistency to function well, the shakedown can be both physically and psychologically devastating.

One primary way that people who are incarcerated experience epistemic injustice, i.e. harm to their capacities as knowers, is through the institution's intentional construction of feelings of helplessness. The LoCI-Wittenberg University Writing Group argues that these feelings are "designed to…prevent the subversive [epistemic] character that is required for a more critical epistemic lens."[40] Members of the groups cite the example of the pressure to participate in gangs for both status and protection as leading to the view that education and other non-gang related activities are not valuable or viable uses of one's time in prison. Furthermore, these non-gang-related activities might also put the individual in an unsafe situation in their rejection of the gang or by lacking the protection afforded by gang membership.

The bureaucratic structure of the prison adds another layer to the construction of helplessness that people living inside of prison experience. Because in many prisons incarcerated people cannot participate in educational programming until they are within a particular window of release. In some Ohio prisons, for example, the window is within five years of release. Even when one is within this window, the queue to get into these programs is long and many people experience "feelings of helplessness to create change or grow intellectually in the ways that are legitimated socially [on the outside], thus contributing to the problem of feeling intellectually inferior….An inmate feels as if they are in a holding pattern until they are eligible to participate in activities that can help them grow in ways that carry social and epistemic weight when one is released from prison."[41] This is even further exacerbated for people serving long sentences because they might not be eligible for educational programming until they have served 20-25 years of their sentence.[42]

39. LoCI-Wittenberg University Writing Group, "Epistemology of Incarceration," 11.

40. Ibid., 13.

41. Ibid., 14.

42. Ibid.

Perhaps more unsettling is what the LoCI-Wittenberg University Writing Group refers to as being "institutionalized," a practice or habit of thought in which people who are incarcerated engage in behaviors such as "ritualistic cleaning, such as the boiling of toothbrushes or food bowls, the unnecessary compulsive compartmentalization of personal property, and the wearing of state prison uniforms even when it is not required, such as in the evening when an inmate can wear one's own clothes."[43] This level of institutionalization reflects the psychological and epistemological damage that results in the embodiment of an institutionalized carceral state, thus embodying, in some cases literally by the wearing of institutional clothes off hours, institutional epistemic injustice.

Lisa Guenther in *Solitary Confinement: Social Death and Its Afterlives* (2013) describes an epistemic state she calls "cellular embodiment," similar to the ones described above.[44] She explains,

> In theory supermax prisoners [prisoners in long term solitary confinement] learn how to "contain" themselves; they learn how to moderate their behavior in accordance with certain rules that give them access to more or less bodily comfort and more or less living space on the basis of a punishment-reward system. … But in practice, confinement in a supermax cell undermines prisoners' agency by blocking their experience of spatial and social depth, literally confining them to a Control Unit, where their only choices are mapped by a flow chart of automatic acts and consequences, punishments and rewards, that allow little or no room for negotiating the complexity of perceptual or social life within or beyond prison.[45]

The supermax cell shuts down epistemic agency, creating institutionalized individuals who bear institutional epistemic injustice on their bodies like the toothbrush boilers and off-hours uniform wearers. Guenther describes self-battering, which consists of throwing oneself against a wall, as a frequent occurrence in supermax cells, this is a practice of "both refusing and confirming the logic…that structures cellular embodiment."[46]

These examples indicate that incarceration, at least as we do it in the US, happens in institutions structured to shut-down the epistemic agency of their subjects, and their methods ensure that the body of the incarcerated person takes on the state of incarceration. Being deprived of this critical agency affects the development of key epistemic virtues that are necessary for advocating for one self as a patient. Most of us know how challenging health care can be living on the outside with access to resources, including family members, internet resources, and multiple care providers to help us make decisions, but imagine being ill in prison when you have been molded to be epistemically ineffective, unable to make decisions, unable to ask for what you need, and unable to show your vulnerability. Furthermore, imagine being at the mercy of a system in which you are not a patient but a prisoner.

The embodied epistemic state of being institutionalized and the more general experience of epistemic injustice is worrisome for anyone in prison and anyone who is ill in prison, but it is especially concerning for elderly people who are incarcerated because they are likely to have served long sentence and thus increased the degree to which they are institutionalized. These patients are also more likely to have a chronic illnesses and physical limitations than their younger counterparts. Furthermore, their high degree of institutionalization means they are less likely to be in a position to advocate for the own care.

43. LoCI-Wittenberg University Writing Group, "Epistemology of Incarceration," 15-16.

44. Lisa Guenther, *Solitary Confinement: Social Death and its Afterlives* (Minneapolis: University of Minnesota Press, 2013), 183.

45. Guenther, *Solitary Confinement*, 184.

46. Ibid.

Punishment on Top of Punishment

End of life issues are especially fraught for people who are incarcerated because they have little to no autonomy in where they die, with whom they die, whether they die shackled or unshackled, or whether their wishes will be taken into account. Ronald Aday, one of the top researchers on aging and incarceration states: "In an institution such as a prison, which controls living as well as dying, a sense of helplessness is almost unavoidable."[47] When people are moved from their standard housing unit to the medical unit, they lose contact with their bunkmates, lose access to programming and activities, and they live in a much more restrictive and highly monitored situation that allows for less contact from the outside. For someone who has a temporary health crisis, this move may be disconcerting, but it does not usually result in longer or permanent isolation and higher level of carceral supervision as it does for those facing the end of their lives. The very permanency of this move can be physically, socially, and emotionally devastating to a person who is incarcerated.

Aday reports that the stigma of dying while incarcerated is the "ultimate defeat, the ultimate punishment" for people who are incarcerated.[48] Many incarcerated people see death in prison as an extension, an unjust extension, of their punishment. In their interviews with elderly male inmates about end of life issues Handtke et al. (2017) support this view. For example,

> Martin (57 years) stated: 'You know, whatever crap someone has done, after a certain amount of time humanity has to accept that he has been punished enough'...Claude (67years) described not releasing a prisoner at the end of life amount[ing] to a death penalty: These guys who will finish their days in prison with a terminal illness, I find that worse than a death sentence....It is a death penalty, indirectly....He will die in prison so he is sentenced [to death]. He is sentenced twice, it's a double sentence. He is sentenced, and then he is sentenced again by the illness.[49]

Furthermore, in Aday's study of males who are incarcerated he reports that men who die in prison worry that it will be a "disgrace to their family."[50] Thus, Aday states that incarcerated people feel ashamed for "dying as a prisoner, and regret at dying without atonement or forgiveness."[51] To avoid thinking about the stigma of dying in prison, this ultimate punishment on top of years of carceral punishment, Aday reports that one-third of elderly male inmates state that they shut-down any thoughts of death. This common theme is echoed in this statement by an elderly inmate: "When I think about death, I just have to turn it off...The last thing I want to think about *in here* is death."[52]

Deaton and Aday's 2010 research on elderly women who are incarcerated show that when they become preoccupied with death, they are more likely to experience death anxiety than males who are incarcerated, with 67% of the women surveyed stating they frequently thought about death and half of them stated they were bothered by these thoughts. One woman reflected, "To be so sick and so locked up, and you don't have any way of getting help, and you look out there and you don't see a guard anywhere for maybe 20 or 30 minutes, and you think what if I have a heart attack and I can't get out. What if the power goes down? That really scares me."[53] Another woman relayed: "The death anxiety is very high, due to the lack of medical care that we get. The majority of the time, [inmates die] because they did not have the medicine that they needed, but more often, because they were left in a critical condition and couldn't get anyone to respond."[54]

Like elderly men who are incarcerated, elderly women in this study were also concerned about the negative stigma of dying in prison. One woman stated "I'm a sister, grandmother, mother, and I feel like after 10 years it's going to be

47. Ronald Aday, "Aging Prisoners' Concerns Toward Dying in Prison," *Omega* 52, no. 3 (2006), 201.

48. Ibid., 208.

49. Violet Handtke et al., "The Collision of Care and Punishment: Ageing Prisoners' View on Compassionate Release," *Punishment and Society* 19, no. 1 (2017), 7.

50. Aday, "Aging Prisoners' Concerns," 209.

51. Ibid.

52. Ibid. Emphasis added.

53. Dayron Deaton and Ronald Aday, "The Effect of Health and Penal Harm on Aging Female Prisoners' Views on Dying in Prison," *Omega* 60, no. 1 (2010), 59.

54. Deaton and Aday, "Effects of Health," 60.

a waste to die here."[55] Another woman felt, "It's more of an embarrassment for my family, not me since I would be dead," and another shared a similar sentiment, "I have thought about dying in here, how terrible it would be for my children and family."[56]

The vast majority of women in this study, 83.1%, stated that they have no actual fear of death, it is the process of dying in prison that they fear. Like some of the men in Aday's other study, the women used avoidance or denial to shut-down their anxiety about dying in prison. One woman stated: "It's hard to deal with the thought of dying in prison. I can't deal with the thought," and so "I don't think about dying in prison."[57]

Though this is an understandable approach to take, it is representative of institutional epistemic injustice as a form of structural violence, where the very structure and functioning of the institution, the fear of punishment and humiliation on top of punishment, puts people who are incarcerated in a position where their best epistemic option for emotional survival is a refusal to recognize or plan for death in prison. This tactic, though in many ways harmful, makes even more sense when one understands what it is like to be cared for in a prison medical ward.

The insidious nature of institutional epistemic injustice, the value we place on people who are incarcerated, and the ways in which these function together come to a head in the prison medical ward. Prison medical wards are low budget, low tech, and low comfort. They are poorly staffed spaces where nurses and doctors are paid well below their counterparts working on the outside. Well-qualified health care workers do not often choose to work in prisons. Nurses in prison frequently have less education than nurses practicing in a more traditional setting, such as a hospital.[58] Most prison nurses are licensed practical nurses, LPNs, with one year of training.[59] Doctors who practice in prisons are frequently those who have licensure issues on the outside, but are readily employed by prisons, which don't have the same licensure standards.[60] In Louisiana, for example, 60% of the physicians working in the state prison system have disciplinary records that affect their licensure and ability to practice medicine on the outside.[61] As Chang reports,

> Dr. Sidney Wolfe, a physician and director of health research at the consumer advocacy group Public Citizen, called Louisiana's situation "unethical" and "dangerous." You're winding up having people who don't have any choice being where they are, getting taken care of by people with demonstrable previous records and problems with the way they practice medicine."[62]

Furthermore, though medical practitioners on the outside frequently have too many patients for whom they are responsible and too little resources, the situation in prisons is much worse. A prison nurse, who may have minimal training, can have up to 500 patients for whom she or he is responsible for providing care and administering medicine. Additionally, these nurses and doctors have less diagnostic equipment available to them to make their assessments of patient health.[63] Thus, at prison health care is significantly compromised from the outset.

But this is only the tip of the iceberg and points at a larger, more insidious problem that affects the health of people who are incarcerated. Just as people who are incarcerated can become "institutionalized," so can the health care workers that treat them. Unlike most people who work in the prison system, nurses and doctors are not trained to work in a prison or with incarcerated people. At first glance one might assume this is a good thing because they are not coming in to the system enculturated in its habits. Yet, because there are few health workers in prisons but many correctional officers, nurses and doctors receive on-the-job prison training and socialization

55. Deaton and Aday, "Effects of Health," 62.

56. Ibid., 63.

57. Ibid.

58. M. Katherine Maeve and Michael Vaughn, "Nursing with Prisoners: The Practice of Caring, Forensic Nursing or Penal Harm Nursing?" *Advances in Nursing Science* 24, no. 2 (2001), 49.

59. Ibid.

60. Ibid.

61. Cindy Chang, "Many Doctors Treating State's Prisoners Have Disciplinary Records Themselves," *Times-Picayune*, July 29, 2012.

62. Ibid.

63. Maeve and Vaughn, "Nursing with Prisoners," 49.

from correctional officers. Thus, their sense of who an incarcerated person is and how they should be treated is transferred to them by correctional officers. Furthermore, like most people on the outside, health care workers come in to the prison setting with a sense of what they believe those in the carceral system deserve, which tends to be punishment and a lack of entitlement to good care. M. Katherine Maeve and Michael Vaughn in their article "Nursing with Prisoners: The Practice of Caring, Forensic Nursing or Penal Harm Nursing" (2001) describe this as penal harm medicine and nursing. Penal harm is the view that the role of prisons is to inflict punishment through causing people who are incarcerated to feel pain and suffering, emotionally and physically. Maeve and Vaughn explain, "[P]enal harm medicine and nursing exist when any health care provider supports and enforces penal harm through nursing and/or medical actions."[64] They argue that this type of medical care has become so routine in the prison system that it passes as a normalized standard of care:

> Upon employment in correctional facilities, nurses are taught not to hold conversations with prisoners, that 'empathy [with prisoners] will be your downfall,' and not to develop any kind of relationship with an inmate, even right down to [having] a cup of coffee. Training films warn new employees that inmate politeness should always be viewed as a form of manipulation, implying that inmates are less than human in their ability to be naturally polite. In very real ways, during orientation processes at jails and prisons, nurses are substantively ordered not to care.[65]

As Maeve and Vaughn point out that while it is important for any health care worker to keep appropriate boundaries between themselves and their patients, it is unethical "to conflate nursing and custodial roles so that the punishment interests of the institution overwhelm the healing and caring mission of nursing."[66] This taking on the model of the penal system is a type of institutional epistemic injustice that becomes embodied in two ways: 1) The behavior, practices and ethics of health care workers become misaligned because of their identification with prison system, not the care system. They thus come to embody a correctional role, not a health care role. 2) The institutional epistemic injustice of penal harm health care is taken on bodily by people who are ill and incarcerated. Thus, incarcerated people frequently experience what I would describe as "healthharm" instead of healthcare. As a result, an elderly inmate cannot even contemplate death in prison. Dying in prison is a defeat and humiliation precisely because of this penal healthharm system.

There is substantial evidence in case law that penal harm healthcare results in negative health outcomes for patients who are incarcerated. Maeve and Vaughn's article presents several examples of patients who were told they were faking their symptoms to get attention only to die while in the infirmary. One example they highlight that shows some of the conflicts and outcomes of this model is "Geiger v. Bowersox." In this case a person incarcerated in Missouri, Randy Geiger, asked a prison nurse for a prescription for Maalox. The nurse prescribed the Maalox and asked a correctional officer to deliver it to Geiger. After receiving and taking the medication he began vomiting and throwing up blood. The correctional officer had substituted floor wax for Maalox. Although the nurse did not administer the floor wax, he or she acted illegally and unethically in his or her responsibilities to the patient by failing to recognize the harm mentality that this officer embodied.[67]

These examples of malpractice, and quite frankly assault and human rights violations in the Geiger v. Bowersox case exist in spite of 1976 Supreme Court decision in *Estelle v. Gamble*, which mandates that prisons cannot act with deliberate indifference to inmates' medical needs. They must provide them with care. People who are incarcerated and ill are not only vulnerable be-

64. Maeve and Vaughn, "Nursing with Prisoners," 58.

65. Ibid., 59.

66. Ibid.

67. Ibid., 14.

cause of their own state of being institutionalized, the people who are responsible for caring for them are also institutionalized, epistemically and ethically shutdown in terms of how and why they should provide care for these patients. Consequently, they have the potential to compromise the health of the patients in their care. Many of us recognize that prison is a broken system. It is also system that breaks people that it has a custodial responsibility to care for.

The End: Projects That Are Personal

Most of our projects are personal. I became interested in this research because of my relationship with Dee X and Kenneth and because I worry about what it would be like for them if and when they die in prison. In many ways this has gotten more personal for me. In addition to teaching in a men's prison, I also teach in a juvenile detention center. In 2014 a former student of mine, Tyrin, who was 17, shot and killed another 17 year old. It was a horrible and tragic crime that reshaped many lives. Tyrin pled guilty to the crime and was sentenced to a minimum of 33 years and a maximum of life. He will first go up for parole in 2047 when he is 50 years old, an old man by prison standards. I began writing to Tyrin in May of 2016. I send him philosophy books and other things to read, and we talk about philosophy and a whole lot of random and interesting things. Since June of 2016 he has broken his knee or had it broken by someone else—he hasn't been clear with me on that—and he was sent to the medical ward. He may have a permanent limp from the injury. While in the medical ward he was stabbed in the arm by another inmate in early August and was then was put in solitary confinement because the knife could not be located. He remained in solitary confinement until early April when he was transferred to a higher security prison, one that is described as the "most violent prison [in Ohio], troubled by gang activity, high drug-use rates and inmate complaints about use of force by corrections officers."[68] The same report states that educational opportunities at Lucasville are vastly inferior to other Ohio prisons and that there is restricted access to the library. In fact, Tyrin asked me to please send more books.

When I think of the toll that this physical and emotional violence are taking on his now 21-year-old body, it is very clear to me why and how people age so rapidly in prison. When I think about the issues in this paper its Tyrin, Kenneth, and Dee X that I think of, people at both the beginning and end of their time in prison and both at the beginning and end of their lives. I believe it is important for us to name these people, to refuse to let ourselves become numb to this system or to remain naïve about its processes and effects. Our job is to not let ourselves become institutionalized, for us to refuse to be helpless and inactive in the face of these multiple levels of deeply engrained injustices because we have choices and options that Kenneth, Dee X, and Tyrin do not.[69]

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BIBLIOGRAPHY

Aday, Ronald. "Aging Prisoners' Concerns Toward Dying in Prison." *Omega* 52, no. 3. (2006): 199-216.

Anderson, Elizabeth. "Epistemic Justice as a Virtue of Social Institutions." *Social Epistemology* 26, no. 2 (2012): 163-73.

Binswanger, Ingrid A, Patrick M. Krueger, and John F. Steiner. "Prevalence of

68. Alan Johnson. "Lucasville Prison Remains Most Violent in State," *The Columbus Dispatch*, March 8, 2016. http://www.dispatch.com/content/stories/local/2016/03/08/lucasville-prison-remains-most-violent-in-state.html.

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Chronic Medical Conditions among Jail and Prison Inmates in the USA Compared with the General Population." *Journal of Epidemiology and Community Health* 63, no. 11 (Nov 2009): 912-19.

Bourdieu, Pierre. *Outline of a Theory of Practice*. Cambridge: Cambridge University Press, 1977.

Bureau of Justice Statistics. "U.S. Correctional Population Declined by Less than 1 Percent for the Second Consecutive Year." December 19, 2014, https://www.bjs.gov/content/pub/press/cpus13pr.cfm.

Carson, Ann E. and William J. Sabol. "Aging of the State Prison Population, 1993–2013." Bureau of Justice Statistics. Washington DC: US Department of Justice (2016).

Chang, Cindy. "Many doctors treating state's prisoners have disciplinary records themselves." *Times-Picayune*, July 29, 2012.

Deaton, Dayron and Ronald Aday. "The Effect of Health and Penal Harm on Aging Female Prisoners' Views on Dying in Prison." *Omega*, 60 no 1 (2010): 51-70.

Duin, Diane K and Mary Helen McSweeney-Feld. "The Aging Male Inmate: Long-term Care Service Needs and Resulting Policy Implication." *Journal of Pastoral Counseling* 40 (2005): 97-106.

Foucault, Michel. *Discipline and Punish.* New York: Vintage, 1977.

Fricker, Miranda. *Epistemic Justice*. Oxford: Oxford University Press, 2007.

———. "Can There Be Institutional Virtues?" In *Oxford Readings in Epistemology (Special Issue: Social Epistemology*, Vol. 3, edited by T. Gendler and J. Hawthorne, 235-52. Oxford: Oxford University Press, 2009.

———. "Group Testimony: The Making of a Good Collective Informant," *Philosophy and Phenomenological Research* 84, no. 2 (2012) 249-76.

Frye, Marilyn. *The Politics of Reality: Essays in Feminist Theory.* Trumansburg, NY: The Crossing Press, 1983.

Handtke, Violet, Wiebke Bretschneider, Bernice Elger, and Tenzin Wangmo. "The Collision of Care and Punishment: Ageing Prisoners' View on Compassionate Release." *Punishment and Society* 19, no. 1 (2017) 5-22.

Gatlung, Johan. "Violence, Peace and Peace Research." *Journal of Peace Research* 6, no. 3 (1969): 167-91.

Guenther, Lisa. *Solitary Confinement: Social Death and its Afterlives.* Minneapolis: University of Minnesota Press, 2013.

James Doris J. and Lauren E. Glaze "Mental Health Problems of Prison and Jail Inmates." Bureau of Justice Statistics. Washington DC: US Department of Justice (2006).

Johnson, Alan. "Lucasville Prison Remains Most Violent in State." *The Columbus Dispatch*. March 8, 2016. http://www.dispatch.com/content/stories/local/2016/03/08/lucasville-prison-remains-most-violent-in-state.html.

LoCI-Wittenberg University Writing Group. "An Epistemology of Incarceration: Constructing Knowing on the Inside." *philoSOPHIA* 6, no.1 (2016) 9-26.

Maeve, M. Katherine and Vaughn, Michael. "Nursing with Prisoners: The Practice of Caring, Forensic Nursing or Penal Harm Nursing?" *Advances in Nursing Science* 24, no. 2 (2001): 47–64.

Maschi, Tina, DeborahViola, Keith Morgen, and Lindsay Koskinen. "Trauma, Stress, Grief, Loss, and Separation Among Older Adults in Prison: the Protective Role of Coping Resources on Physical and Mental Well-being." *Journal of Crime and Justice* (2013): 1-26. https://doi.org/10.1080/0735648X.2013.808853.

McHugh, Nancy. *The Limits of Knowledge: Generating Feminist Pragmatist Cases for Situated Knowing*. Albany, NY: State University of New York Press, 2015.

Medina, José. *The Epistemology of Resistance*. New York: Oxford University Press, 2013.

Mills, Charles. *The Racial Contract*. Ithaca, NY: Cornell University Press. 1997.

Office of the Inspector General, "The Impact of an Aging Inmate Population on the Federal Bureau of Prisons" Washington DC: US Department of Justice. Revised 2016.

Rikard, R. V. and E. Rosenberg. "Aging Inmates: A Convergence of Trends in the American Criminal Justice System." *Journal of Correctional Health Care* 13, no. 3 (2007): 150-62

Roberts, Samuel K. "Aging in Prison: Reducing Elder Incarceration and Promoting Public Safety." Center for Justice, Columbia University, November 2015.

United States Supreme Court. *Estelle v Gamble*, 429 US 97 (1976).

Vestal, Christine. "For Aging Inmates, Care Outside Prison Walls." *Research and Analysis*. *The Pew Charitable Trust*, August 12, 2014. http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2014/08/12/for-aging-inmates-care-outside-prison-walls.

Wick, Jeanette Y. and Guido R. Zanni. "Challenges in Caring for Aging Inmates." *The Consultant Pharmacist* 24, no. 6 (June, 2009): 424-36.

Williams, Brie A., Karla Lindquist, Rebecca L. Sudore, Heidi M. Strupp, Donna J. Willmott, and Louise C. Walter. "Being Old and Doing Time: Functional Impairment and Adverse Experiences of Geriatric Female Prisoners." *Journal of American Geriatrics Society* 54, no. 4 (2006): 702-07.

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Ending Life

A Public Holistic Response

James R. Mathews Jr.

This text raises many poignant points about the criminal justice system, primarily dealing with health care treatment. She states that she would have remained ignorant of the health needs of people who are incarcerated if she had not been teaching prisons. This directly relates to equally poignant and accurate statements, "Because of the physical structure of some institutions, such as prisons, they literally preclude people living outside of these oppressive structures to see in… . Their very physicality presents an epistemic barrier to those of us on the outside from knowing what is happening on the inside." This says to me, and I think this is her point, that we need to become active agents in the discussion of what is physically and epistemically just when it comes to the medical treatment of incarcerated persons (specifically the aging population).

I believe, after reading this text, the vast majority of readers will re-access how they view the treatment of prisoners as a whole, specifically the availability or lack of availability of adequate medical care for the aging prison population.

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