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## From the Warehouse to the Deathbed: Challenging the Conditions of Mass Death in Prison

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## **Abstract**

The purpose of this project is to analyze the crisis of mass incarceration by placing the conditions faced by elderly, terminally ill, and dying prisoners, as its main point of focus. Much of this crisis was built through post-1970s American penal policies which set in place tough sentencing laws, increased prosecutorial power, and ultimately, led to a significant growth in the prisoner population. Today, elderly and terminally ill prisoners make up the fastest growing population inside of prisons. Few of these prisoners are approved for early release, and instead die while incarcerated. This has resulted in a condition of mass death within a system of mass incarceration. In order to manage the crisis of mass death, many prisons have constructed specialized hospice care units, internal to the prison facility. As the practice of providing hospice care inside of prisons becomes more and more commonplace, it is crucial to document their functions. The following project attempts to provide a critical analysis of the origins of prison-hospice care, the benefits and limitations of these facilities, and the experiences of prisoners within these spaces. Ultimately, this project seeks to highlight the conditions which have naturalized mass death inside of American prisons, and invites its readers to look beyond the horizon of mass incarceration.

## **Keywords**

mass incarceration, elderly, terminally ill, mass death

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*Ernest Kikuta Chavez*

### **Abstract**

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## **Introduction: The Crisis of Mass Incarceration and Mass Death**

In 2011, the U.S. Supreme Court ruled in *Brown v. Plata* that the conditions inside of California's prisons were in violation of the Eighth Amendment right against cruel and unusual punishment (Chettiar, 2011). In particular, Justice Kennedy announced that, “the medical and mental health care provided by California's prisons falls below the standard of decency that inheres in the Eighth Amendment” (Egelko, 2011). As a result of *Plata*, the California Department of Corrections and Rehabilitation (CDCR) has been ordered to reduce its prison population. This controversial mandate has been the focus of much debate around prisons, not only in California, but also nation-wide.<sup>1</sup>

Although there are several implications that follow *Plata*, one of the most significant issues that is brought to light is the relationship between mass incarceration and mass death. The term *mass death* refers to the massive number of elderly and terminally ill prisoners who are dying inside, from lack of proper medical and health care. The American Civil Liberties Union predicts that by year 2030, there will be over 400,000 elderly prisoners incarcerated nationwide (ACLU, 2012). This growing “geriatric prisoner population,” represents a crisis of mass

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1 Although *Plata* presents some of the most recent litigation involving medical care in prisons, the issue is not a new one. In *Estelle v. Gamble* (1976), the Supreme Court cited violations of the Eighth Amendment in the medical treatment of prisoners. In *Wellman v. Faulkner* (1983), the Court stated that prisons and jails are obligated to provide adequate medical care (Linder, Enders, Craig, Richardson, & Meyers, 2002). More recently, in 1996 the American Correctional Association called for prisons to provide special medical provisions for terminally ill inmates (Byock, 2002).

incarceration, as well as the normalization of medical neglect in prison healthcare (Simon, 2014, p. 6). Prison institutions have responded to this crisis of mass death by building hospice facilities that are designed to manage the bodies of prisoners who approach imminent death.

The purpose of this project is to critically analyze the establishment of prison death-care facilities. The first section of this essay attempts to trace the destructive path of mass incarceration which came to produce mass death in the first place. In other words, this section poses the question: How did we arrive at where we are today? The second section focuses on the first prison hospice units built in the U.S., the expansion of this model to other locations, and the challenges and obstacles that have emerged in the development of these facilities. A third section aims to construct a critical analysis of the lived experience of prisoners who volunteer as caregivers in prison hospice. This section draws heavily from qualitative studies conducted in the fields of corrections and healthcare, and also poses the important question of how scholars in this field can best engage in research that is not only informative, but also ethical and non-exploitative of prisoners. A final conclusion section will examine the implications and limitations of utilizing hospice care inside of prisons as a solution to mass death. In doing so, this section will also offer a vision for an alternative solution that is based on a politics of shared social responsibility and the abolition of mass incarceration.

### **“Geriatric” Prisoner Populations: The Production of Mass Death**

Although there are competing theories as to the genesis of mass incarceration in the U.S., it is apparent that once this carceral project was set into motion, it expanded at a high level

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of speed, intensity, and destruction. The population of people in prisons in the U.S. grew by 442% between 1970 and 1995 (Wacquant, 2009). The most recent data demonstrates that there are over 1.3 million people in prisons, and that the total population of incarcerated persons in the U.S. today is at 2.4 million, with another 3.9 million on probation (Wagner & Sakala, 2014). Laws such as “Three Strikes and You’re Out” at the state level and mandatory minimum sentencing at the federal level have increased the number of prisoners receiving life sentences (Wacquant, 2009). As a result of these punitive sentencing measures, the number of prisoners serving sentences of 20 years or more grew from 186,514 to 308,827 between 1990 and 1999 (Linder et al., 2002). The average length of sentences nearly tripled between 1980 and 1990 from 20 months to 57 months (Reimer, 2008).

One result of this rapid and intense carceral expansion is the emergence of what is being referred to as a “graying” or “geriatric” prisoner population (Aviram, 2015; Bronstein & Wright, 2006; Reimer, 2008; Simon, 2014). As Aviram (2015) writes:

[The] inflated proportion of older prisoners incarcerated for the decade and a half between 1995 and 2009 continues to affect the increasing geriatric population due to the lengthy sentences that will likely keep them behind bars for most, if not all, of their lives (p. 123).

Today, aging prisoners make up the fastest growing subset inside of America's prisons, and as stated earlier, the ACLU warns that this population is projected to reach upwards of half a million by the year 2030 (ACLU, 2012; Maschi, Morrissey, & Leigey, 2013). This population has been steadily

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increasing over the past few decades. In 1997, the population of prisoners considered elderly, was close to 55,000 – nearly double what it was in 1990 (Craig & Craig, 1999). In 2002, there were a reported 120,933 prisoners over the age of 50. By 2010, this number reached roughly 223,000 (Maschi et al., 2013). Aging prisoners represent a particularly vulnerable population since prisons are not institutionally designed to provide long-term medical care (Simon, 2014). The prison population boom, coupled with longer sentencing guidelines at both the state and federal levels, has resulted in a condition of mass death wherein, hundreds of thousands of prisoners will either develop serious medical conditions while incarcerated, or will grow old and die before they ever reach parole or release. (Aviram, 2015; Reimer, 2008; Supiano, Cloyes, & Berry, 2014).

In *Mass Incarceration on Trial*, Simon (2014) underlines the important point that as sentencing policies became more punitive, health problems were exacerbated among the prisoners. Simon writes, “These changes created an increasingly 'geriatric' prison population with a much higher burden of chronic illness, than in the past [...]” (p. 6). Additionally, prisoners are deemed to age faster, because of the accumulation of strain and stressors than are exacted upon their bodies. Prisoners aged 55 and up are typically understood to be 10 or 11 years older, physiologically, than their chronological age (Rikard and Rosenberg, 2007). The draconian penal policies of the past forty years have created an entire carceral system that normalizes the subjection of elderly and ill people to bodily decay and eventual death inside of

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prison.<sup>2</sup> The rising numbers of aging prisoners has culminated into the current situation in which some 42% of state prisoners report having a serious chronic medical condition, while being 55% more likely to have diabetes and 90% more likely to suffer from a heart attack than their non-incarcerated peers (Supiano et al. 2014). The current day American prison system is facing a crisis. As prisons and states continue to come under the scrutiny of courts and progressive organizations, how will this system manage the mass death that it produces?

### **Prison-Hospice: Building Deathbeds Inside and the Management of Mass Death**

The destructive path of mass incarceration has reached a point of crisis in which the number of dying prisoners has become so great, that prisons have had to redesign their internal structures in order to be able to process and accommodate mass death. Prisons have resorted to a strategy of importing hospice practices, inside, in an attempt to not reduce or eliminate death, but to regulate and control how a prisoner will die. In the end however, hospice itself does not challenge the fundamental conundrum of mass death. It merely serves to alter its aesthetic and material surface. The following section will provide a detailed definition of the operations of hospice care in prison, and draw attention to its successes as well as its shortcomings.

Hospice can be defined as a facility that provides palliative care for individuals who are approaching the end of life. Palliative care differs from the curative medical model. While curative medicine is based on extending physical life for as long as possible, palliative care on the other hand seeks to ease

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2 A study conducted in 2006 showed that there were 3,000 in-custody prisoner deaths in just fourteen different prison hospices (Bronstein & Wright, 2006)

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the process of dying. Hospice seeks to provide emotional comfort, mental comfort, and spiritual connections for the dying (Tillman, 2000; Wright & Bronstein, 2006; Wright & Bronstein, 2007). The philosophy behind palliative care is that death is a process of living in that it is a time for reflection upon one's own life, a time for reconciliation and fixing relationships, sharing the stories and lessons learned from life, and recognizing the contributions and differences that one has made in the world (Byock, 2002). A motto of hospice is that "Healing does not always mean curing a disease" (Johnson, 1999, p. 239). There are, however, several obstacles to providing meaningful end-of-life care inside of an institution that is designed to dehumanize. Even when hospice is "successful" inside of prisons, this does not alter the fundamental problem of mass death – it merely shifts the discussion from challenging mass incarceration, toward the goal of providing "humane" channels for death.

Prisoners are often understood by much of the public as dangerous outcasts who do not deserve compassion even when they are facing circumstances of prolonged and painful death (Byock, 2002; Courtwright, Raphael-Grimm, & Collichio, 2008; Craig & Craig, 1999). In fact, achieving any level of humane treatment for people living behind bars is a difficult challenge. Mahon (1999) writes, "The demonization of the offender in the political discourse has made it difficult for advocates of quality end-of-life care for prisoners to be successful both in enacting and implementing reform" (p. 213). In other words, public opinion regarding prisoners is largely unfavorable. Yet, the past two decades have seen a steady increase in the number of hospices emerging inside of prison walls.

In 1987, the first experimental prison hospices were established – one in Springfield, Missouri at the U.S. Center for

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Federal Prisoners, and the other at California Medical Facility (CMF), Vacaville (Bick, 2002; Bronstein & Wright, 2006; Craig & Craig, 1999; Ratcliff, 2000). Initially, these hospices were built as a response to the HIV and AIDS epidemics in prisons. In 1997, there were 20 formal hospice programs in operation (Heller, 2000; Ratcliff, 2000). In 2005, there were more than 35 hospices established across the country (Byock, 2002; Head, 2005). By 2011, this number had grown to 69 (Hoffman & Dickinson, 2011). This pattern indicates that the prison hospice is a growing phenomenon.<sup>3</sup>

Louisiana State Penitentiary, also known as “Angola” – named after one of the former slave plantations upon which the prison was built – serves as a “model” hospice program (Tillman, 2000; Waselchuck, 2010). In 2000, the hospice at Angola received the Circle of Life Award from the American Hospital Association<sup>4</sup> (Head, 2005; Heller, 2000). Angola has been an inspiration for other prison hospices, and its coordinators have been consulted by officials from other prisons who seek information about the best way to manage a prison hospice

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3 Several noteworthy patterns emerge among the hospice units at Angola, CMF, and other institutions. First, hospice patients are granted special rights that other inmates are not. These include extended visiting rights with family and other inmates, retrofitted cells that attempt to provide more comfort, offering preferred diets, and of course, 24-hour care when on vigil (Bauersmith & Gent, 2002; Craig & Craig, 1999; Yamapokskaya & Winson, 2003). In addition, although not all hospices have cemeteries as part of the prison, many do practice a yearly memorial to honor those who have passed inside of prison (Yamapokskaya & Winson, 2003).

4 The Circle of Life Award is presented for innovations in palliative and end-of-life care, by the American Hospital Association.

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(Cahal, 2002). Angola houses 5,100 prisoners, over half of whom are serving life sentences, and an additional one-third, serving 20 years or more (Evans, Herzog, & Tillman, 2002). Of the total number of 5,100 Angola prisoners, some 85% are expected to die inside before ever seeing release into the free world (Waselchuck, 2010). Rather than treating hospice as a celebratory crite of humane death-care however, it is crucial to remember that this is still a highly oppressive institution.

The hospice at Angola is fitted with roughly 40 beds, and its cells are retrofitted to resemble hospital rooms rather than prison cells. The walls are painted, pictures are hung, and quilts handmade by prisoner volunteers decorate the facility (Head, 2005). The Angola hospice unit also has a chapel in which prisoners are able to provide funeral services when a patient passes (Head, 2005; Waselchuck, 2010). Prisoners who still have family members on the outside may choose to have their bodies received by family and buried outside of the prison. However, many prisoners choose to be buried at the Angola cemetery, Point Lookout II. The reason being that many of these prisoners have lost contact with their families on the outside, and after spending decades on the inside, the most meaningful relationships that remain are with other prisoners who have become “family” (Evans et al. 2002; Waselchuck, 2010).

Prisoners at Angola used to be buried in coffins made of particle board or styrofoam (Evans et al., 2002; Tillman, 2000; Waselchuck, 2010). Since the founding of the hospice, however, a prisoner named Richard Liggett who is trained in carpentry, began to build hand-crafted, wooden coffins that are lined with satin on the inside (Tillman, 2000). Liggett trained two other prisoners as casket builders, before he built his own casket and checked himself into hospice. He died shortly thereafter as he

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was suffering from advanced liver and lung cancers (Waselchuck, 2010). Angola holds funeral processions for each prisoner who passes. During these processions, prisoners act as pallbearers, a prison choir group sings *Amazing Grace*, and those who knew the deceased speak share their memories. Occasionally, outside family members of the deceased are even allowed to attend the funeral services (Tillman, 2000; Waselchuck, 2008). Although the funeral rites exercised by prisoners at Angola certainly represent a meaningful departure from the norm of dying in prison, it ought to still be understood, not as a site of humanitarian celebration, but as a site of struggle against an oppressive institution that naturalizes mass death.

A second prison hospice that is also considered one of the most well-developed is located inside of CMF, Vacaville, about 20 miles southwest of Davis, California. CMF houses a population of 2,183 inmates. Whereas most prisons in California report a handful of expected deaths each year, CMF, because of its hospice unit, reported 86 deaths between August 2012 and August 2013.<sup>5</sup> Similar to Angola, the hospice rooms at CMF have been converted to closer resemble a hospital room than a prison cell (Johnson, 2011). Pictures are hung on the wall, a small television is provided, and the barred windows are covered with shutters. Prisoners in this unit are provided with hand-woven quilts donated to the hospice by a local church in Vacaville. When a prisoner is believed to have less than 72 hours to live, they are put “on vigil,” meaning that another inmate volunteer will sit at the bedside of the dying, 24 hours a day, in

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5 These data were taken directly from the CDCR's monthly Computer Statistics (COMPSTAT) report, retrieved from [http://www.cdcr.ca.gov/Reports\\_Research/Offender\\_Information\\_Services\\_Branch/Monthly/Monthly\\_Tpop1a\\_Archive.html](http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/Monthly_Tpop1a_Archive.html).

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order to ensure that no one dies alone (Johnson, 2011).

These moments of compassion are rare sights to find inside of a prison facility. The fact that such practices can exist inside of a prison attests to the powerful devotion that some prisoners have to their prison family. In a sense, these prisoners have been able to create rituals that seem to pierce the callousness of the prison environment. As tempting as it is find solace in these exceptional moments, it is crucial not to lose analytical sight of hospice as a state strategy for death management, and as an ongoing site of struggle.

Even those who advocate for prison hospice must grapple with the issue of how to provide quality, end-of-life care inside of an environment that is built for dehumanization and deprivation of freedom (Craig & Craig, 1999). There are several contradictions that lie between the purpose of hospice and the purpose of prison. Prisons emphasize security, and any additive that might compromise security is received with skepticism. Prison hospices represent spaces in which inmates are granted “special rights” that are absent in most other cellblocks. Prisons are often hesitant to build hospice facilities, because this would supposedly allow too much freedom of movement among prisoners (Craig & Craig, 1999). For this reason, most hospice units are small, and it is difficult to gain access to them. In fact, prisoners can only apply for transfer into hospice facilities under the strictest of medical conditions, such as receiving a prognosis of having less than six months to live, and signing a Do-Not-Resuscitate (DNR) order (Boyle, 2002; Yampolskaya & Winston, 2003). This implies that price that prisoners must pay in order to gain admission into hospice care, is an acceptance of imminent death.

Not only is hospice care itself an ethically contested site of struggle, but even those who do reach hospice are not guaranteed to receive the care that they need. Palliative care often involves the prescription of pain-reducing drugs, however, the use of these drugs inside of prison are strict, and not everyone who needs them will be able to receive them (Byock, 2002; Craig & Craig, 1999; Ratcliff, 2000). Prison officials have argued that the facility must strike a balance between security and providing for the medical needs of the prisoner (Head, 2005). This can result in greatly compromising the stated purpose of hospice.

Perhaps the greatest challenge in providing hospice care, however, is the hierarchical and distrusting relationship between staff and prisoners (Ratcliff, 2000; Tillman, 2000). As Craig and Craig (1999) explain, the prison staff believe that, “the inmates are trying to manipulate us,” while prisoners believe that, “the staff are out to get us” (p. 726). For example, staff often restrict the movement of prisoner-volunteers inside of hospice as a precaution. In doing so however, they are effectively reducing the capacity of these individuals to provide much needed care for others. It has been argued that one way to mitigate this strained relationship is to provide training to prison staff (Tillman, 2000). When prison hospices are first established, many act in collaboration with an outside hospice organization, and prison staff receive training from these professionals. Case studies such as Tillman's (2000), which argue for the successful collaboration between staff and prisoners, ought to be understood as an exception to the rule. Such training is certainly better than none at all. However, no amount of formalized procedure is likely to alter the problem of powerful hierarchies that fuel distrust and antagonism within prisons, in the first

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place. In other words, the deeper issue of the impossibility of recognizing the humanity of prisoners, inside of an institution that naturalizes their dehumanization, remains unchallenged and unchanged.

Those who celebrate prison hospice as a humanitarian success are perhaps overly hasty in doing so. Even if this strategy has successfully altered the aesthetic and material field of death inside by providing retrofitted rooms, vigils, and funeral rites for prisoners, it has left intact the fundamental punitive logic that has sustained mass incarceration over the past four decades. If every so-called “success” of hospice can only be displayed against the backdrop of a person's body slowly deteriorating in a prison deathbed, then to what end can this really be considered a favorable outcome or meaningful prison reform?

### **Toiling in Death-Care: The Experiences of Prisoner Caregivers in Hospice**

The most complicated and yet, most telling part of the story of hospice in prison is the role that the prisoners, themselves, fill. It is complicated precisely because there is a paradox that lies between the prisoners who perform emotionally and physically exhausting labor for the sake of the dying, and, the prison institution which does not let up in its production of mass death. In other words, there is a constant antagonism between the forces of compassion produced by prisoner-caregivers, and, the forces of mass death produced by prisons. In this respect, one of the challenges faced by scholars who wish to understand prison hospice, is to successfully articulate the violence and oppression of slow death in prison, while simultaneously, paying respect, and giving credit to the prisoners who display invaluable compassion, devotion, and will power toward one another. The following section attempts to critically

analyze the labor of prisoner caregivers in hospice, while refraining from eclipsing the crucial value of this labor.

Prisoners who volunteer in hospice often develop meaningful relationships with their patients. These relationships challenge the ordinary customs of prison institutions because they push back against the norm of dehumanization. Rather than treating prisoners as sub-human, caregivers and patients oftentimes arrive at an understanding of each other as “family.” Not only do prisoner caregivers provide physical aid to a patient, but they also produce significant meaning within an environment that is largely void of meaning. For this reason, the prisoners who labor as caregivers are understood to be the single most important component of prison hospice (Tillman, 2000; Wright & Bronstein, 2007).

This dynamic also brings to light a crucial point, that to some extent, insider-outsider relationships within the context of the prison and the “free world” cannot be reconciled. In other words, no one aside from another prisoner can begin to understand how difficult it is to live in a prison institution. Not only is the institution itself physically, mentally, and emotionally destructive, but many prisoners are haunted by the traumas, burdens, and ghosts of their past lives. This leaves many prisoners unable to form meaningful connections with anyone in the free world, while they remain incarcerated. Many prisoners inside of hospice prefer to be cared for by a peer, because there exists a potential for mutual understanding of what the patient is going through (Craig & Craig, 1999). This is especially true for the many prisoner caregivers who understand the grave consequences of their work – that they, themselves, will one day fill these very same deathbeds.

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The very concept of “family,” takes on new meaning inside of prison. Those who are serving long sentences have often lost contact with their families and loved ones in the outside world, or have never had any to begin with (Tillman, 2000). One prisoner describes the loneliness that comes with living out a life in prison:

Sometimes we lose all contact with our real families for any reasons. And for some of us this is the only families we have. So giving someone an ear to listen to or a shoulder to lean on might mean everything. No one wants to feel alone. (Hoffman & Dickinson, 2011, p. 11).

The relationships that prisoners have with one another are of the utmost importance. The role of these connections is intensified during the process of death because of the amount and quality of time that is shared between a caregiver and a dying patient. One caretaker describes how the experience of knowing his patient has changed his life. He writes, “I have learned that life is precious and so is what I do with it... I know that if I'm of no value to anyone else, I am of value to him.” In turn, his patient responded, “A month ago I didn't know you existed, but now you are my family” (Byock, 2002, p. 113). Building meaningful relations in prisons is a difficult task, and thus the connections described here, represent rare and important exceptions.

Another powerful aspect of caregiver-patient relations, is the extraordinary amount of time that prisoners can end up spending together in this setting. For many in hospice, it is not an unusual experience to sit with a close friend through the entire process of a slow death. Caretakers can devote weeks or even months of their lives to looking after a patient, only to end

up sitting with them at bedside, while they take the final breaths of life. In one example at the Angola hospice, a volunteer named Felton Love, spent eight hours per day, seven days per week, with his friend and patient, Timothy Minor. When Timothy entered the advanced stages of his illness, he lost his ability to speak, and because they spent so much time together, Felton learned to read Timothy's facial expressions and carry a conversation with him like this. Felton describes the intimate friendship that he has shared with Timothy, saying, "When he sees me come through the door, his eyes light up like a Christmas tree. Not a day passes that he don't tell me how much he loves me and how much he's just glad I'm here" (Waselchuck, 2010, p. 65). Close friendships such as these, demonstrate the strength of human devotion, even within the painful conditions of dying inside of prison.

The impact that working as a caregiver in prison hospice can have on a person is difficult to ascertain. The experiences are intensely personal, and for an outsider, impossible to fully grasp. A qualitative study published by Supiano et al. (2014), attempts to illuminate the personal meanings behind these experiences, by collecting narratives and testimonies from prison hospice caregivers. The study posits that these volunteers experience a tremendous depth of grief, feelings of significance, spiritual contemplation, and internal reflection in experiencing the deaths of their patients and friends. To provide a few brief examples, grief was understood as a difficult yet necessary part of hospice care. One prisoner reflects:

It's a part of you gone. It hurts so bad, all you can do is cry. You don't care who see you cry. One time, I meant I felt like if you cry too, it's weak. You know, men don't cry. But as I begin in this program it make no difference

who see me cry. I feel for that person when they leave, but I know one day I did everything I could for him, and he know I was right there with him. He wasn't by himself. (Supiano et al., 2014, p. 89).

Even though the labor involved in hospice is exhausting, this caretaker acknowledges that it is a necessary task, because it is deeply meaningful for the dying patient. Another prisoner describes the emotional struggle of toiling in death-care, as follows:

When a patient die on me, I say, 'I can't handle it no more.' But I go back to the patients. I know that other people need me, just like he did. If I was there for him, I could be there for someone else. And that will motivate you. That will keep you going, that you know somebody else needs you. You can't stop now. And I refuse to stop now. (Supiano et al., 2014, p. 90).

Prisoners who labor caregivers are painfully aware that their labor is emotionally agonizing, and perhaps even traumatic, and yet, they bear the burden and responsibility because they understand that it is desperately needed, and no one else will do it. It is difficult, if not downright impossible, for an outsider to comprehend these experiences. Perhaps this suggests that such prisoner-caregivers understand more about the value of life and death, than those who reside in the “free world,” since they do have the option or privilege of taking daily life for granted.

Furthermore, there is a perception that prisoners who volunteer in hospice gain a piece of mind by providing care for others. Many prisoners express that they are hoping to find redemption, both for themselves as well as for their loved ones, through these actions. One prisoner explained that his reasoning for doing the work that he does is to provide his family on the

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outside, with a memory of him as something other than a “bad” person:

I can say to myself that even if I never be forgiven by all the people I hurt, I see them daily in my care of others. I'd like for my name to be used so my children and family can see, I did something other than be the bad guy. (Hoffman & Dickinson, 2011, p. 9).

Similarly, another prisoner shares his hope for redemption, saying, “My mother died when I wasn't there for her and I would like to give back to someone now” (Hoffman & Dickinson, 2011, p. 6). Each of these examples portrays a search for something that will fill the void of regret. Many prisoners desire a sense of self-fulfillment through the moral responsibility of caring for those who are dying. At the CMF, Vacaville hospice, Chaplain Knauff says of the inmate volunteers, “They are always trying to atone for their crimes. They talk about the meaning hospice has given them, allowing them to do what they can't do for others on the outside” (Craig, 2002, p. 164). Whether this desire is born out of a self-seeking desire for absolution, or if it closer to a selfless act of altruism, is aside the point. What stands out as noteworthy from these studies is the reciprocal and mutually beneficial relationship that develops between caregiver and patient. The patient receives comfort and companionship, while the caregiver is able to fulfill a desire to care for someone.

To revert back to a previous argument, there remains a risk in celebrating these alleged “successes” of prison hospice, without recognizing the crisis of the bigger picture. The involvement of prisoners as hospice volunteers has been said to have a “transformative effect” on these prisoners (Byock, 2002; Wright and Bronstein, 2007). Also it has been claimed that since

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hospice is a space in which prisoners and prison staff work together toward the common goal of care-taking, that this represents an emerging “neutral zone” within the prison where the normal severity of prison rules are greatly reduced (Tillman, 2000). Perhaps there is some truth to these claims. It is important however, to remain mindful of the ways in which the relationship between *institution* and *prisoner* is one that is based, first and foremost, on hierarchy. This remains true even within the context of hospice. The personal narratives of prison hospice caretakers reveal a tremendous depth of compassion and devotion between people in prisons. At the same time however, they also reveal the problematics of great emotional and physical struggle and suffering that comes with toiling in spaces of death-care.

It would be remiss for scholars to celebrate the “transformative effect” of individual prisoners, or the production of a supposed “neutral zone,” in prisons, without also critically analyzing the production of mass death that underwrites such claims. Rather than allowing each analysis of hospice care in prison to simply become integrated into support for piecemeal reform, scholars must challenge the fundamental conditions of the current day American penal landscape – the same conditions that have led to the production and the continuing reproduction of mass death, that we now face. If scholars wish to avoid eclipsing the experiences of prisoners who toil in the spaces of death-care, what better way to accomplish this, than to target the root conditions that have produced this crisis in the first place?

### **Conclusions: Freedom Beyond the Horizon of Hospice**

Activists and scholars who acknowledge the crisis of the aging prisoner population have pointed to legislative strategies in the hopes of mitigating its effects. For example, the ACLU

(2012) supports repealing tough sentencing laws and supporting early release and medical release for elderly and terminally ill prisoners. Although these proposed solutions are certainly aimed in a helpful direction, they also fail to address the lack of support that prisoners face, if they were to be released. Medical provisions, housing options, and social support will be difficult for many to obtain in the case of release. Additionally, these proposed legislative actions do not confront the difficulty of being approved by the Board of Parole for early release in the first place (Aviram, 2015).

Absent a clear solution, current day prisons continue to build new hospice facilities within their walls. Although prison hospice has shifted the aesthetic and material dynamics of dying in prison, it has not address the socio-historical conditions of mass incarceration that continue to haunt the free world. As new prison hospices continue to emerge, there are several considerations that must be taken into account regarding the dangers of establishing hospice care as a norm inside of prisons.

First, hospice has the effect of naturalizing death inside of prison. This paradox recalls Foucault's (1977) critique of prison reform: "Prison 'reform' is virtually contemporary with the prison itself: it constitutes, as it were, its programme" (p. 234). Prison hospice, as a project of reform, complies with mass death through an acceptance of a "gentler" death. Ultimately, this legitimizes the logic of incarceration and reproduces the permanence of prison institutions. In other words, hospice creates an illusion of this form of dying in prison as "humane." As long as the institution of imprisonment is allowed to continue transforming its technologies of death through so-called "reforms," the conditions of mass death will be made to

disappear. Thus prison hospice ought to be understood cautiously, as a strategic adaptation for managing mass death.

Furthermore, when heavy focus is placed on the problematics of mass death, this diverts attention from more fundamental criticism of the system of mass incarceration as a whole. In doing so, the normalization of mass death reinforces the ideological effect of prisons. The ability of the prison institution to escape widespread criticism is partially embedded in its ability to blame deeply-rooted social problems onto individuals rather than structural inequalities. On this point, Angela Davis writes:

We thus think about imprisonment as a fate reserved for others, a fate reserved for “evildoers”...The prison therefore functions ideologically as an abstract site into which undesirables are deposited, relieving us of the responsibility of thinking about the real issues afflicting those communities from which prisoners are drawn... This is the ideological work that the prison performs – it relieves us of the responsibility of seriously engaging with the problems of our society, especially those produced by racism and, increasingly, global capitalism. (Davis, 2003, p. 16).

In a sense, prisons are designed to escape critical examination, because such an analysis would reveal a destructive system for which society must bear partial responsibility. Prisons and the people who fill them continue to exist because they serve as a scapegoat from confronting the macro-level, structural roots of what is called “criminality.” This is what Davis refers to as the *ideological effect* of the prison. Thus it is made easy for “free society” to forget, or never confront the fact, that the evils of mass

incarceration and mass death, are linked with deep social problems.

Perhaps the task of imagining a solution to these problems ought to begin by recognizing what we in the “free world,” share in common with dying prisoners. As one prisoner-caregiver reminds us, “At the end of the day whether you are incarcerated or free, you will die. How you die depends on others if you are unable to help yourself” (Hoffman & Dickinson, 2011, p. 7). If we, as actors in the free world accept this to be true, then perhaps the burden of conjuring up better alternatives, is a responsibility that we share with these “others,” whether we like it or not. Can it be, that the way forward is not to search for solutions internal to the current system, but to think of shared pathways that take seriously the possibilities of radical transformation of society? On this note, Kim Gilmore reminds those who are engaged in the work of prison abolition:

In this moment, it may seem more difficult than ever to envision a state that supports humanity rather than eviscerates the possibility of freedom and health for so many of its people. Yet it is precisely now, when prisons crowd the physical and psychic landscape, that imagining abolition is most critical. (Gilmore, 2000, p. 196).

The task of challenging mass death and mass incarceration is a monumental one that is shared by all who assume a place in society. In ignoring this evil and allowing it to perpetuate, we stand witness to a further erosion of our shared responsibility that comes with living in a democratic society. The cost we pay is the loss of the ability to claim that this is a society that values

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human life and the conditions of freedom. The way forward then, must begin with the abolition of institutions of non-freedom and human containment, in order to pave the path toward a better society.

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