

WARDS OF THE STATE:
CARE AND CUSTODY IN A PENNSYLVANIA PRISON

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ABSTRACT

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In this dissertation, I examine the challenges and contradictions as well as the expectations and aspirations involved in the provision of healthcare to inmates in a maximum-security prison in Pennsylvania. In 1976, the Supreme Court granted inmates a constitutional right to healthcare based on the notion that a failure to do so would constitute “cruel and unusual punishment.” Drawing on two years of ethnographic fieldwork from 2014-2016 in the prison’s medical unit with inmates, healthcare providers, and correctional staff, I demonstrate how the legal infrastructure built around this right to healthcare operates in practice and the myriad effects it has for those in state custody.

Through traversing the scales of legal doctrine, privatized managed care, and collective historical memory, bringing these structural components to life in personal narratives and clinical interactions, I advance the notion that the physical space of the prison’s medical unit is a “ward of the state” – a space of care where the state itself is “made” through interactions among individuals who relay and enact the legal regulations on inmate healthcare. I also argue that incarcerated men themselves are cast as “wards of the state” – the biological and financial property of the state placed in its custody. As such, the state has an obligation to care for inmates as quasi-citizens who are granted a right to healthcare in the setting of rights deprivation as punishment. Even though this right primarily exists as a mandate not to inflict too much harm, it also creates the conditions for which inmates come to rely on the state for life-saving and life-sustaining services, perpetuating historical forms of racial subjugation through care and containment in the process.

Finally, I outline the paths inmates make for themselves to find meaning amidst the multitude of losses they experience and to seek belonging amidst disenfranchisement.

While the forms of legal, personal, and political recognition that are available to inmates are few, the structural features of an institutionalized right to healthcare open up spaces for them to envision futures and to make both personal and structural appeals to justice with both tragic and hopeful consequences.

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N/A

Author's Note

The names of research participants appearing throughout the text are pseudonyms, used to provide anonymity and protect confidentiality. I refer to people using constructions and honorifics that reflect how I and other people in the prison addressed one another. For example, I use the title Dr. followed by last name to refer to physicians and first names for midlevel healthcare providers. Inmates are referred to typically as Mr. and their last name. I use first names to refer to some inmates with whom I had closer relationships and who had more substantive engagement in the research. Public officials, major private corporations, and state institutions are identified by name. There is contextual specificity afforded by the use of real names, and their status as publicly identifiable entities supports this usage. While many of the details appearing throughout the text are particular to the prison where I conducted my fieldwork and its regional setting, using real names of the institutions and the handful of companies that travel across states bidding for correctional healthcare contracts also helps situate my field site within the larger carceral landscape in the United States.

Very minor stylistic edits are occasionally made to quotations in order to enhance readability in the translation from spoken to written language. Nuances in dialect, word usage, and syntax are maintained wherever possible. In instances where I feel they are important to my analytical and representational aims, paralinguistic gestures, inflections, and pauses are included. I use the pronouns “he” and “him” when necessary to refer to inmates. This is meant to enhance clarity and consistency and not to erase the experiences of trans, feminine-presenting, and gender non-conforming inmates who were incarcerated at SCI Graterford.

Glossary and Terminology

Although the term “jail” typically refers to a local institution that incarcerates pre-trial detainees and those convicted of sentences that are usually shorter than two years, and the term “prison” refers to state or federal institutions incarcerating those serving longer sentences for crimes they have already been convicted of, my research participants used these two terms interchangeably to refer to SCI Graterford, along with the more antiquated term “penitentiary.” When referring to “jails” as they are commonly understood, my research participants typically called them simply “county [jails]” (e.g. “Inmates are coming in from county” or “I spent two months in county”). I stay close to the generally accepted usages in my own writing; however, colloquial usages do come through in some transcriptions.

Common Terms and Abbreviations:

DOC – Department of Corrections
CO – Correctional Officer
RHU – Restricted Housing Unit
MHU – Mental Health Unit
POC – Psychiatric Observation Cell
MOC – Medical Observation Cell

Introduction

“Welcome to Graterworld”: A Mix of Nightmare and Reality

When I arrived at the prison for the first time, I rode in from a neighboring town’s train station with Ron, one of the administrators whom I had originally contacted to shadow as a medical student. We drove through an unassuming Pennsylvania town, passing a school, some residential areas, and a few commercial buildings. As we drove on, I expected a gradual change in scenery that would signal our proximity to the prison – for us to eventually leave more populated areas and become progressively more secluded, as though the prison would actually exist in a world apart from the one I was accustomed to inhabiting. To my surprise, we suddenly made a right hand turn off the main highway, right across from a small, rural bar. I looked up and saw the eponymous street sign: “Prison Road.”

After making the turn, we crossed over a slab bridge and ascended up a small hill on Prison Road until we reached an intersection. I saw to my right a large wooden sign with the state seal and “Pennsylvania Department of Corrections, SCI Graterford” written on it in yellow block letters. As we passed it, we went through a metal bar gate that was swung open, officially entering the prison grounds. We started driving through rolling fields, which were still covered in a morning fog, and I spotted a few deer grazing at the forest edge – an idyllic scene juxtaposed with the behemoth stone ochre prison just coming into view through the fog on the horizon. Ron noticed that I was taking in the scenery and commented, “It’s kind of an amazing sight isn’t it? We own all this land.”

Graterford was the largest (and one of the oldest) prisons in Pennsylvania. A men’s maximum-security facility, its census usually stayed around 4,000 inmates – its full capacity – at any given time with inmates from all around Pennsylvania, but mostly from the southeast region around Philadelphia. It also served as a transit facility for people recently sentenced, arriving from county jails on their way to a central processing facility near the state capitol in Harrisburg to be assigned a security classification. As such, it housed a variety of men who were convicted of a vast array of crimes. Those who

were housed there more permanently as part of their classification typically had been convicted of more serious crimes or else had longer sentences from multiple convictions. The population was also one of the most racially skewed of the prisons in Pennsylvania. Around 60 percent of the inmates were black, 15 percent were Latino, and 25 percent were white.

After giving me a few instructions on how things were going to operate at the front gate and what to expect on my first day in the prison (leave your keys and cell phone, always keep your ID, stay within earshot of a correctional officer, try not to be startled by the constant noise of slamming steel, etc.), Ron confided to me something about healthcare services in the prison just before we parked. He told me that he felt as though one of the biggest challenges to providing healthcare in the prison was that the inmates simply had unrealistic expectations for how medicine operated in the prison. “They expect too much, too fast,” he said. He then began describing how recently a black inmate was preparing to sue the state, alleging racial discrimination because his cancer was not being treated:

They just don’t understand that there are protocols. We follow the protocol the same way they do on the outside. People get cancer, and sometimes it goes away... and sometimes it comes back. Your being black or being in prison doesn’t have anything to do with that. You know, working here sometimes can be like being in a Fellini movie – a surreal mix of nightmare and reality.

Ron’s words continued to resonate with me throughout the two years I spent at Graterford conducting fieldwork shadowing the healthcare staff and hanging out with their inmate-patients in their infirmary rooms and chatting with them in clinic offices. The surrealist image that he evoked captures the disorienting experience of how some of what happened in the prison clinic at times seemed shockingly exceptional and at times shockingly ordinary; it brings to mind the hand-wringing frustration of watching providers and inmates talk past each other, clashing ideologies of entitlement to care and medical need, and the arbitrariness with which rules and medical management were sometimes enforced. Ron’s final line was also a concise explanation for how Graterford – or “Graterworld” as some often called it to acknowledge this foreign, other-worldly

quality – was able to be both a part of the familiar experience of contemporary healthcare as well as an institutional limit case in how contemporary healthcare adapts to racialized punishment and confinement. Eventually, as I returned to the short anecdote on cancer care that Ron shared on that first day, I came to realize how central it was to the narratives that inmates were sharing with me, and how they engaged with healthcare services. The themes of legal arbitration, expectations for care, and structural racism began guiding the work that I did with the staff and inmates at Graterford and the questions that I asked of them and the institutions that they inhabited. What *were* inmates’ expectations of healthcare services while they were under state custody? What guided their attempts to make claims for healthcare in the law, and were these attempts successful? If so, what did they accomplish? If not, why? And how did race and racism both engender inmate’s perception of poor care that Ron described and also facilitate such a description in which the dynamics of racial oppression and incarceration are disavowed?

After we parked, Ron and I entered the double doors toward the front gate of the prison. To our left were lines of wooden benches where friends and family members would mull about waiting for access to the prison’s visiting room. The space was lined with small metal lockers in which they could place their belongings before being patted down to see their loved ones. On this day, two women – one black and one white – sat on the benches tending to their young children, who were fidgeting impatiently, eager to run around on the linoleum floors. The white woman tugged at her young son’s shirt as he attempted to escape. While we waited for the giant metal door to open, I noticed the long row of government officials’ portraits up on the wall, arranged by rank. In the middle was President Obama, with Pennsylvania’s Governor Tom Corbett to one side and the Secretary of Corrections John Wetzel on the other and other state cabinet members to each side, manifesting a material presence of the state. Just below in gold, ornate script on a blue background it was written: “Through these doors walk Pennsylvania’s finest correctional professionals.”

The door on the opposite side slammed shut, followed by the mechanical noise of the door in front of us opening. We line up to pass through the metal detector and pass

our coats to the side for the officer to pat down. The steel door slammed behind us, and again the opposite door opened. The thick, opaque metal moved aside, revealing an expansive corridor about a football field long. Some guards mulled about along with some inmate workers. We didn't walk far down the corridor before branching off to another steel door. The officer behind the Plexiglas of the security bubble buzzed us into a small waiting room filled with inmates wearing yellow jumpsuits. The whole area beyond the main corridor had an acerbic, metallic smell coated with stale cigarette smoke and disinfectant. When I imagine the prison still, the smell sits solidly in my nostrils. We then passed through another locked steel door into the medical unit.

Going Upstate

My interest in prison healthcare comes from a previous ethnographic project attempting to understand non-adherence to HIV medication among free clinic patients in Philadelphia and Vancouver, British Columbia. In Philadelphia, most of the people I worked with were diagnosed with HIV either when undergoing insurance physicals or when they were incarcerated. For some reasons that I outline below, prisons in the United States have become a site of primary health service provision for those too structurally vulnerable to reach or be reached by stable services in their communities. The sociopolitical climate of the US is such that the most precarious members of its polity are more likely to encounter the state and have their health needs addressed as criminals when it becomes an obligation than they are to have their health prioritized as full-fledged citizens.

Gaining research access to a site that is typically restricted both to research and to the lay public was facilitated by my status as a trainee in a dual MD-PhD program, where I entered as a shadowing medical student interested in correctional healthcare. Entering as a potential future employment recruit in this light helped diminish any barriers that would have otherwise raised suspicions about my motives for being there, even now I made known my interest in public health issues and social inequality. After six months of shadowing, I gradually began bringing up the idea of doing doctoral research at Graterford. My orientation as a trainee afforded me multiple advantages, especially in navigating the vast hierarchical divides between the different groups from

which I was trying to elicit perspectives on prison healthcare. The healthcare providers tended to see me as an interested student, eager to learn about the structural challenges of delivering healthcare in a prison and the challenges posed by the behavioral dynamics of their patient population – namely manipulation and entitlement.

My status as a trainee also afforded many advantages with inmates. Building trust in longstanding relationships is an essential component of the anthropological method of ethnography and essential to break through impressions management, especially when conducting fieldwork in a closed setting like the prison, where I was unable to follow my research participants throughout most of their daily lives and their typical routines and was limited in my ability to triangulate information from multiple sites and sources, instead relying mainly on interviews, clinic appointments, and observations within the general population over long periods of time. My status as a student helped me have conversations with inmates that were more informal and aligned me as someone who was not a direct part of the cadre of healthcare providers that often seemed antagonistic or unresponsive to their concerns. As a healthcare provider in the making, I was still “reachable” to inmates and not yet fully bound to the logics of managed care or fully socialized into seeing them through the same lenses of criminality and juvenile entitlement as they felt other healthcare providers had. Mostly, however, the trust of inmates came from showing them human consideration, sitting with them in private clinic offices without supervision and listening to them talk. Telling their personal narratives and working through some of their thoughts, which were sometimes made to seem conspiratorial or out of touch with reality, served as a cathartic and grounding moment for many of the men I worked with.

In addition to gaining the trust of inmates, it was essential for me to gain the trust of the healthcare providers who saw friendly interaction and interest in inmates as suspicious and even dangerous. I address this notion and the taboo of “fraternization” with inmates more in Chapter 3, but for now it suffices to acknowledge that this taboo limited healthcare providers’ engagement with inmates beyond the strict clinical objectives of their interactions. Although providers sometimes had empathetic rapport with their patients and got to know them personally – indeed, one could argue their job

required them to do so – providers were cautious about overstepping boundaries with inmate-patients that I was required to cross given the nature of my research. Although I was careful never to jeopardize the security of the facility or break any of the institutional policies, ethnographic work was made difficult in situations where I was not allowed to share contact information or follow up informally with some of my research participants. Fortunately, the concern of overstepping boundaries between inmates and staff was so tied up in the idea of sexual misconduct that allegations of fraternization were directed away from me as a male, focusing more on female staff members.

Many anthropologists discuss entering into systems of reciprocity with the people involved in their research to gain trust, build solidarity, and provide certain benefits for people in exchange for their participation. The expectations that men had for benefits I could provide them were limited to a sense that I might allow their stories to reach a wider audience, but many of them attempted to write opinion pieces for publication or worked closely with family members or activist organizations on their own, so I felt I had to carefully balance writing on their behalf with their abilities to tell their own stories in their own venues. Ultimately, I had to rely on the advice of one of my primary research participants, Eddie, who will reappear throughout these pages, when he fittingly used a legal metaphor to describe my authorial relationship to him as his “power of attorney,” giving me license to “trust my instincts” in order to stay true to his ideas and allow his visions and insights to be heard through my own analysis.

I was also seen as having the social and cultural capital to help with their some of their cases, even if it meant sending an email to the innocence project or telling them where to find certain forms from the District Attorney’s office. Rarely did men ask me to do this, however. Again, the taboo against fraternization meant that they were very hesitant about asking any staff member (and in this regard they saw me as a staff member) to do anything for them, lest they be seen as attempting to emotionally and/or financially manipulate them. As I got to know some men and their families, they would ask for some logistical support with legal paperwork or fundraising, which I often provided.

Beyond the challenges of forming interpersonal relationships in prison, merely getting approval to do the work was not an easy or straightforward task. The process itself mirrored the bureaucratic labyrinth inherent in all state-run institutional settings. Furthermore, the approval process (although I was unaware of it at the time) reinforced the structural importance of the law governing medical care in the prison. At the time when I applied to the research review committee at the Department of Corrections for approval of the project, Graterford and two other in Pennsylvania were the subject of a class action lawsuit filed with the ACLU alleging a lack of sufficient access to mental health care for inmates in solitary confinement. The only question I got from the review committee was about whether or not my study of healthcare services would include mental health. I wanted to keep the project open at the time and assumed that their question centered on whether I could assure that I would protect their anonymity, provide adequate follow up, and attest to their competence to consent to participate in the research. Only after the project was initially denied did I learn that they did so to avoid having me look into the provision of mental health care services while the Department of Justice concurrently ran an open investigation of their practices.

The research and this resulting dissertation is born out of a social and political commitment to understanding how a system of care can be multifaceted and fulfill various functions from a legal obligation to supportive care to a system of structured exploitation that fosters rather than alleviates suffering. As such, I steer away from often-proffered straightforward narratives about poor healthcare in prison. Such narratives typically revolve around disastrous outcomes from substandard medical care experienced from an inmate convicted of a non-violent or low-level offense who is easily seen as a victim the political process of mass incarceration rather than a less sympathetic inmate who is trying to get access to expensive care, or suffered a common complication of a chronic disease. The latter is the much more common scenario, and I believe we stand little to gain from the reproducing the former. While those situations exist and are indeed tragic, repeating them in isolation does not alert us to the complexities of either institutionalized and monetized care delivery or the political process of mass incarceration. Because healthcare in prison is surrounded by a legal infrastructure to

support it, it does have some positive qualities. Flattening that quality does a disservice to the human richness – the triumphs and tragedies – of receiving and providing care in state custody. As such, many of the incarcerated men who appear in this dissertation are convicted of serious crimes and are serving life in prison. Their stories are complicated, hopeful, sorrowful, and perplexing.

“Who is he getting healthy for?”/“Treating the sickest first”

The medical unit at Graterford contained two segments, physically separated by locking doors. The first was a triangular segment, which contained clinic offices and the unit’s dispensary, where emergency care and care that required supervision like insulin injections and minor procedures was administered. The second was a larger segment just beyond the clinic offices that was shaped like a T – the infirmary, which provided pre- and post-procedural care, hospice care, and care that required the supervision of a medical professional (e.g. IV fluids, administering medications through ports, extensive wound care, etc.) but did not warrant extra resources that the prison did not have, for which they needed to be admitted to a nearby community hospital. Mostly, the infirmary cared for older or disabled men who could not otherwise function or move around on the block without disrupting the prison’s daily administrative activities.

The main avenues for care delivery were through the infirmary and dispensary, “chronic clinics” for specific disease processes like diabetes, hypertension, and HIV, and “sick call” where inmates would place written requests to see a healthcare provider, and the provider would see patients in a clinic office at the end of one of the large cellblocks in the general population. Early in my fieldwork, I observed care during the Hepatitis C chronic clinic. Because of how highly structured care delivery was, discussion of other healthcare needs was considered off limits at these visits. I saw patients with the acting medical director then, Dr. Álvarez, a Peruvian medical graduate who trained in internal medicine in the United States. As the medical director hired by a private company that provides healthcare services to all the prisons in the state of Pennsylvania, Dr. Álvarez saw his job as defined more by his ability to be a good employee to the company than as a good physician to his patients. As such, he often looked for reasons to discontinue or deny medications and made it his mission during his tenure as medical director to

convince the other healthcare providers to present a unified front to consistently deny certain medications and to convince inmates that “prisons were not healthy places” so they could not expect to get better care than they would otherwise get in their communities.

One of the patients we saw that day was Mr. Weaver, a black inmate in his late sixties with a long face, deep wrinkles, and large eyes blurred behind coke bottle glasses. Mr. Weaver had a particular genotype of the Hepatitis C virus and had not responded to a standard therapy that involved pegylated interferon and ribavirin. He and Dr. Álvarez discussed his candidacy for “triple therapy,” which includes those two drugs in addition to a protease inhibitor. The first thing Mr. Weaver did as he sat down across from the doctor was to take out a pencil and a loose sheet of paper folded into eighths to fit into the breast pocket of his prison jumpsuit. He put on his glasses, sat back in the seat, and said, “Read me my liver numbers, doc.”

As Dr. Álvarez opened up his chart and read off the latest set of lab data demonstrating where he fell on a standardized metric of liver failure, Mr. Weaver took heavy notes on these “liver numbers.” After recording his lab results, Mr. Weaver asked if they were good. “What do they mean?” he said.

Dr. Álvarez: Well, your liver isn’t working the best, and that’s a result of your Hep C. Now we tried to treat it before, but you failed this treatment.

Mr. Weaver: By failed, you mean I wasn’t cured?

Dr. Álvarez: Yeah, essentially. The drugs didn’t help you at all.

Mr. Weaver: So, what are we going to do about it?

Dr. Álvarez: Well, there is a new treatment for Hep C, genotype 1, which is the genotype that you have. The DOC [Department of Corrections] only offers this therapy at another facility, which means that you would have to transfer there in order to undergo treatment. But before we get ahead of ourselves, the bigger issue here is that you don’t qualify for the treatment. It adds another drug to the two drugs that you tried before, but since you’ve already failed on those other two drugs, it has a very low likelihood of working.

Mr. Weaver: What are the chances?

Dr. Álvarez: Not good. Bad enough that the DOC won't approve it. It's really only for people who have never been treated with any drugs before. For those people it seems to work better than the two drugs that you had. If you've already failed on those drugs there's no reason to believe the three drugs will work."

Mr. Weaver: [*sighs despondently*] Doc, I wanna do everything I can do to make myself well. Just because I'm incarcerated don't mean I can't take good care of myself. If this option isn't for me, what else can I do?

Dr. Álvarez: You could live a long, healthy life and die of something totally different than your hepatitis. Or, you could develop liver failure and get very sick. I don't have a good way of telling you which will happen. You can petition the DOC for the triple therapy, but you don't really have another option. We can treat symptoms as they arise. Now... if you want to get the triple therapy, you'll have to get another liver biopsy and undergo all the routine screening tests before starting, and you'll have to appeal the prison in order to get approved to be transferred for triple therapy. Given your legal situation, I don't think the DOC is gonna be too happy to send you somewhere else.

Mr. Weaver still wanted to pursue triple therapy, saying that he took his health seriously and contradicting the idea that his "legal situation" would hold him up. He mentioned that there was a previous instance where he sued a prison doctor for giving him false test results, and that he also has ongoing lawsuits against other inmates at the prison for assault. He states that leaving and going to another institution would be actually be valuable for him in escaping the negative ramifications of these lawsuits and seeing them out from a safe environment despite ultimately moving him further away from Philadelphia, where he was from and where his family still resided. Eventually Dr. Álvarez tells him he can apply, but that it's "not worth it."

After Mr. Weaver left, Dr. Álvarez turned to me and said:

Can you believe how ridiculous he was?! That was a classic manipulator trying to play games. You saw how diligently he was taking notes. Otherwise I wouldn't have even told him about triple therapy because I don't think he's a candidate and won't get it approved, but you heard that he had another situation where he sued a prison doc for giving him the wrong information. And he's the type of person who would find out that there's a new type of therapy. But honestly... in the bigger picture, what's this guy doing? I get that he's concerned about his health and wants to take care of himself, which is more than I can say for a lot of the guys here [in prison] but he's talking like taking care of himself is going to mean

something. He's 70 years old. In all likelihood, he'll spend the rest of his life in this place, so who is he getting healthy for?

* * *

About a year later, a group of inmates throughout Pennsylvania began the process of filing a class action lawsuit¹ to gain access to Harvoni, a drug with a high cure rate for Hepatitis C infection that was approved by the FDA about 8 months prior, following similar inmate lawsuits in Indiana, Massachusetts, and Minnesota.² At the time of approval and market release, a course of the drug cost over \$100,000, which was not accounted for in advance of the five-year terms of the contract for the for-profit healthcare vendors who provided healthcare services for the Pennsylvania DOC. In public discourse, the introduction of the new drug and its proposed use in Pennsylvania's inmate population, who had twenty times the incidence of chronic Hepatitis C infection than that of the national average (Larney et al. 2014), raised many questions about the ethics of providing inmates with care that was not yet obtainable for the average American. The first two individual lawsuits attempting to hold the state accountable for providing this new treatment were dismissed. The first suit was dismissed because the statute of limitations had passed for the inmate to make a claim. In the second suit, the judge had declared that failure to provide the drug was unconstitutional in theory, but he dismissed the claim because the inmate had named a staff member who was not directly involved in the oversight of care administration and the decision to treat.

During the initial class action hearing, the DOC developed a *post hoc* protocol to provide treatment to inmates, in which they outlined how they would treat "the sickest inmates first." They had also appointed Claire, a white nurse practitioner with a long term of employment at Graterford, in charge of administering and tracking all of the inmates at Graterford receiving care for Hepatitis C. Despite being a bit scattered and with sometimes-confused intentions, Claire frequently worked with inmates to figure out how she could get them access to the kinds of treatment that they felt they needed, in contrast to Dr. Álvarez. When I sat in with her on the hepatitis clinic one day, where men paraded through, discussing the new drug and asking the same questions that were circulating outside of the prison and in even in some of the legal proceedings surrounding the class

action lawsuit. Those who would be released soon or had family members who also had Hepatitis C were wondering if Medicaid covered it. At the time, it did not, an argument that the state was pursuing in the lawsuit as a rationale for why they should not be obligated to provide it for inmates. Since Medicaid was the most likely form of insurance that an incarcerated person in Pennsylvania would have if released would not cover it, the DOC should not be obligated to do so, so the argument went. With all of the patients, Claire discussed how they were “gradually” expanding the criteria for access to care, but they were “starting with the sickest patients first.” “We are working on getting it to everyone,” she would say, “But it costs a lot, so we have to limit care at first to the people who are sickest, and you’ve got to meet the criteria for that.” Claire shared the state’s protocol for eligibility with me, which not only required extensive evidence of liver damage and its sequelae such as bleeding blood vessels in the esophagus, the accumulation of fluid in the abdomen, and changes in mental status, but also an additional review of any misconducts or medication noncompliance in the patient’s history, which would disqualify them from therapy.³

While most of the inmates seemed to accept the guidelines for eligibility (at least while they were in the clinic with Claire), Claire acknowledged that they saw it as prolonging their disease: “They don’t seem to understand that. They respond, ‘So you’re going to wait until I’m dying?’ And it’s like, ‘No, We’ll see you every 6 months and see how your labs look. It’s a very slow-progressing disease process.’” Later in the day, in between seeing patients in the clinic, I asked her how many inmates at Graterford were currently receiving treatment with Harvoni. “One,” she replied. “He doesn’t even fit the protocol, which is the weird thing about it!”

Apparently the man receiving therapy had liver damage from the virus that was too advanced for the treatment to be considered effective based on the quantified therapy guidelines the department used to craft its policy. When I asked why the state went through all the trouble to outline all these eligibility criteria just to treat one inmate who did not even meet them, Claire replied, “But without treatment he’ll certainly die within the year.” While I briefly thought to myself that perhaps that this was an example of them giving him a chance at therapy because the consequences of his disease were so

imminent, later in the conversation Claire revealed that part of the rationale behind implementing the protocol was so that the DOC could manage the public impression that it looked bad to have inmates suing over effective treatment that the prison was denying solely for cost reasons. I asked her if she meant that this was what was guiding their treatment of the only inmate who did not fit the criteria for Harvoni treatment. “So is that why they’re treating him? Because it would look bad?” I asked. Claire replied, “They’re treating him because he’ll die within the year. It can’t look like we did nothing! At least this way we’re covered when he does die and they try to say that we let it go on too long.”

The transformations in clinical care that took place over the course of these two vignettes and the issues that they introduce crystallize both the themes and the stakes of this dissertation. I am drawn to investigate the types of social value that are bound up in inmates’ health as evidenced in Mr. Weaver’s attempts to seek treatment and Dr. Álvarez’s comment, “Who is he getting healthy for?” I also reckon with the literal monetary value that is placed on providing them with curative therapies, and how their presumed lack deservingness of such therapies relies on notions of punishment and the continual reconstitution of inmates as criminals. Finally, on a structural level, I contend with how both of these issues intersect with the dynamics between the law and the institution’s control over individuals, as in transferring Mr. Weaver to another prison farther away from his family to undergo treatment and the institution’s ability to undermine its own treatment protocols to evade the perception of legal culpability over an inmate’s death. In response to Bourgois and Schoenberg’s emphatic suggestion for scholars to understand the connections between social and physical suffering, specifically through acts of institutional iatrogenesis (Bourgois and Schonberg 2009:80-115), I seek to explicate the relationships between care and custody that shaped inmates’ social worlds and how they came to inhabit them through claims to – and interactions with – healthcare.

The United States is the currently the world leader in incarceration. The U.S. has only 5 percent of the world’s population but contains 25 percent of the world’s prisoners (Travis et al. 2014). There is an expansive literature detailing the harmful effects of

incarceration and the criminal justice system more broadly, including its inherent biases and its role as a tool for race- and class-based systems of control (see for example Alexander 2012; Mauer and Chesney-Lind 2002; Wacquant 2010). While incarceration presents numerous obvious hardships for individuals and their families, it offers at least one potential benefit – greater access to healthcare. Since the 1976 Supreme Court case *Estelle v. Gamble*, prison inmates have been guaranteed a right to healthcare access under the Eighth Amendment protection against “cruel and unusual punishment,” and some public health discourse classifies incarceration as a “golden opportunity” to intervene on health needs (see McGovern 2008; Staples-Horne et al. 2007). However, the literature demonstrating the effects on health that are afforded by the increased proximity to care during incarceration paints a very complicated picture. While racial disparities in mortality decline in prison (see Patterson 2010; Rosen et al. 2008), mortality increases for incarcerated women and white men (Massoglia and Pridemore 2015; supra Patterson 2010). While most negative health effects associated with incarceration are seen after release (Binswanger et al. 2007; Schnittker and John 2007), exposure to infectious diseases, a high chronic disease burden, poor prison conditions, prison healthcare budget constraints, and security issues present challenges to caring for a prison population (see for example Binswanger et al. 2009; Dumont et al. 2011; Greifinger 2007; Pont et al. 2012).

These data demonstrate the need for further investigation into exactly how this complicated picture of healthcare emerges. They invite inquiry into the paradox of promoting an ostensible right to prison healthcare in an environment where health maintenance is hindered by the institutional and ideological constraints of incarceration and where most rights of citizenship are withheld as punishment for crimes committed. As such, there is a need to determine how healthcare is actually practiced behind prisons’ walls and to what effect, an area heretofore neglected due to the logistical and political constraints of studying prisons, which have remained largely unchanged and unaddressed in the 14 years since Wacquant’s call to “carry out intensive, close-up observation of the myriad relations [prisons] contain and support” (2002a:386-7; see also Rhodes 2001; Waldram 2009). This dissertation responds to that call with an ethnographic

understanding of the everyday delivery of healthcare in a Pennsylvania state prison. It tracks the phenomena that have contributed to the merging of care and custody and elucidates the effects it has had for the inmates who occupy these pages and the other 1.5 million incarcerated people in the United States, while also helping us think broadly about systems of citizenship, neoliberal healthcare provision, and state control.

Care and Custody, Building the Modern Prison

Dialectics between punishment and reform, between care and custody, have helped to shape the present reality of mass incarceration in the United States. Recurring historical patterns and processes of subjugation and exploitation mixed with inclusion and humanism have laid the foundation for the persistence of incarceration as a form of social control that relies on notions of reform, rehabilitation, and correction to justify imprisonment (see for example Rothman 1980). As Hirsch (1992) notes, the early republic's legitimacy provided a cohesive front for the *ad hoc* experimentation with forms of statecraft through punishment. New Americans did not, as it were, "invent" the prison *de novo*. Rather, they worked through combinations with older known models of punishment including the English workhouses and existing jailhouses with ideas vested in Calvinist and Quaker ideology, democratic freedom, and Enlightenment rationality. Independence gave new Americans the opportunity to creatively devise new modes of governance and more fitting mechanisms of crime control. These new ideals were not just (or even wholly) formed in opposition to British mechanisms, but importantly incorporated them with their unique sense of individual liberty, meritocracy, and freedom, establishing the new republic's mode of punishment as humane by comparison.

At the same time, prisons re-imagined colonial forms of detaining racial and ethnic difference that were driven by nationalist ideologies and motivated by distinct conceptual hierarchies of personhood that has reflexively attempted to construct a racially homogeneous citizenry (see for example Bosworth 2010; Christianson 1998). Meranze (1996) similarly shows how the prison became a place to work out the paradoxes of the liberal state – one that simultaneously assures the freedom of citizens by denying that freedom to its convicts – and to experiment with forms of punishment that were pronounced to demonstrate a radical break from England's Bloody Code. Thus, through

experimentation with governance that denied people access to citizenship based on their perceived lack of humanity and the simultaneous projection of more humane liberal values, America and the prison “grew up” together. The state and its ideals of freedom and democracy were born in distinction to the particular form of *inhumane* deprivation of those liberties instituted in the prison (Dumm 1987); the prison and society were – and are – mutually constituting (see Garland 1990).

Nowhere in the United States was this method of mutually constituting legitimacy for the state and its forms of punishment that promoted ideologies of care more true than in Pennsylvania. At the turn of the 19th century, Benjamin Rush, a Philadelphia physician, helped invent the system of solitary confinement that was named the Pennsylvania System and utilized in one of the nation’s first penitentiaries, Eastern State, as a way to promote reflection and repentance. Driven by medical logic and the scientific justification of curative practices, the penitentiary promoted the idea of strong governance supported by people and designed to allow people to change and thrive (see Simon 2007). Eddie, a 64 year-old black inmate at Graterford himself described Pennsylvania’s role in this history and how it continued to allow the commonwealth to see itself with an air of authenticity in knowing “what was right” when it comes to care and custody:

They had the first penitentiary in the world, Eastern State Penitentiary, they think they have it all figured out. They done fell behind. They was where it was born, in Pennsylvania... Philadelphia. They think they the shit! They think they don’t have to answer to nobody! This is some of the *attitude* even to today. But, all the other states, they done moved ahead, for real. Pennsylvania not only stuck in the past, but they think because they did something in this history, that they actually at the front. They think what they do is the way forward, when it couldn’t be further from the truth.

Just as the solitary confinement system at Eastern State resulted in higher recidivism and cruel practices that caused severe physical and psychological harm, the modern criminal justice system in Pennsylvania has been mired in controversy, systematically underfunded its public defenders, and lacked systems of support and restitution for the numerous wrongful convictions that have been delivered through the state’s historical use of false testimony and biased jury selection to force convictions,⁴

even as the Department of Corrections has professed to lead efforts to reduce prison populations, close prisons, and curb recidivism.

The early republic's experiments in prison governance cast as humanitarian reform that took place in Pennsylvania and beyond remained at the forefront of the minds of inmates at Graterford, who saw the expansion of these experiments into the realm of medical care. They frequently cited experimentation with prisoners, including the infamous medical experiments on inmates in the Philadelphia Holmesburg jails from the 1950s-70s that were conducted by Albert Kligman, a physician from my home institution, the University of Pennsylvania (Hornblum 1998). They mentioned these experiments as reasons to question medical services as experiments not only in economic governance through healthcare contracts and the extraction of profit for the healthcare vendors rationing healthcare, but also experiments in their health. To them, this reimagining of experimentation evoked other historical experiments with black bodies in the favor of tracking the natural history of disease performed in the Tuskegee Syphilis study and elsewhere throughout medical history (see especially Washington 2006). The forms of structural denial that took place either for legal-logistical (as in Mr. Weaver's case above) or financial (as in the implementation of the *ad hoc* Hepatitis C protocol) reasons reconstituted both their confinement and lack of personhood and belonging.

The mode of incarceration that focused primarily on individual reflection and penitence in the early 19th century quickly gave way to a system of contracted penal labor. McLennan's (2008) labor narrative points out that instituting a system of taxpayer-supported labor and labor training once again relied on the idea that care would accompany state custody. Reliance on the production capacity opened up by this labor market and not the provision of labor services to inmates, which was seen to grant inmates with a form of state assistance not given to the rest of society, created coherence to a system of contracted prison labor and penal servitude despite concern over such overreach of the state. McLennan's work articulates one way that discourses around care and custody took shape in the on-the-ground politics that cast the state in an ancillary role, despite the state's importance in regulating labor and maintaining an image of humane punishment. Indeed it was the guise of progressive reform in steering away from

contracted labor that “inserted an ensemble of alternative disciplinary practices into the vacuum left by the productive labor regime” (189). Similarly, Lichtenstein (2001) sees the state’s capacity or willingness to punish as intricately linked to maintaining an image of labor equality and opportunity.

Progressive Era reforms in the U.S. prison system again promoted a guise of humanism despite failure to sustain those visions (see for example Smith 2009). Reforms in this time period (roughly the late 1800s and early 1900s) were driven largely by the emerging crisis from overcrowding and prison riots and from a changing environment in social science that elaborated a “criminal milieu,” positing that criminal behavior was determined by environmental and psychological factors (Rothman 1980; Sim 1990). Rather than explicit racial justifications for social exclusion, these rationales rested in the (social) scientific and criminalization of people of color and the promise of rehabilitation and reintegration. Reforms were not easily instituted in these already unwieldy institutions, and it was soon realized by officials that sustaining a public image of reform was enough to sustain current practices (1995). Bright’s (1996) post-Reform Era history of Jackson State Prison in Michigan outlines how despite a homogeneous public image of the prison as influenced by humane and rational operation, it remained an environment that was both constituted by changing broader social patterns and helped to constitute those patterns. He shows how “the seemingly monolithic mass of the ‘big house’ can be seen as a highly unstable terrain of contestation, improvisation, improbable ideologies, and impermanent coalitions of power” (5). Thus, reform shaped and was shaped by local contestations around prisoner treatment, which only supported public opinion that something was being done to enact these reforms.

The contemporary climate of mass incarceration in the United States that began in the 1960s has been explained by direct political strategies to deny rights of citizenship and reconstitute forms of racial oppression through the criminalization of race and poverty (see for example Alexander 2012; Tonry 2011). The concurrent divestment in social welfare programs in accord with post-Keynesian, neoliberal economic reforms structured a burgeoning penal-welfare “policy regime” (Beckett and Western 2001) that replaced welfare with prisonfare (Sutton 2004). In effect, the sociopolitical and economic

turmoil of the 1960s that resulted from these spaces of seclusion. In particular, some scholars refer to racial groups and the poor recouping the loss of state services by providing them for themselves, which involved destabilizing the state's monopoly over violence in urban centers and resulted in unprecedented policing of these spaces (Gilmore 1998; Pettit and Western 2004; Thompson 2010) and created the conditions for increasingly visible crime that was defined as such, opening up a convenient penal strategy to cope with social divestment and insecurity (Wacquant 2009).

Like reform efforts that came before them, contemporary attempts to transform prison conditions adapted as a result of the increased incarceration rates over the past four decades. The political economy of divestment in social services in communities created the conditions under which state services were to be provided within the spatial confines, financial constraints, and punitive sovereignty of state institutions. Primarily fought for in the court system (Feeley and Rubin 2000), battles for prisoners' rights solidified the provision of care in the context of custody for the structurally vulnerable in the United States. While these legal battles did help grant the minimal provision of services that were required to not be considered "cruel and usual punishment," like the right to healthcare in *Estelle v. Gamble*, they have had little impact on the conditions that inmates face. Twentieth century analyses of reform movements have shown that they have made modest gains for altering particular programs and have been less successful at changing conditions that assert inmates' basic human – indeed constitutional – rights (see Carroll 1998). Furthermore, those relegated to the punitive end of the carceral state reap its exclusions from the polity in other ways, including the loss of the right to vote (and therefore take place in the democracy that dictates one's punishment) (Wacquant 2005), the ability to have access to higher education and low-income housing (Page 2004), as well as the detrimental effects of incarceration on inmates' social lives, including the recurrence and inevitability of incarceration and the disruption of social and domestic relationships (Price 2015; Mauer and Chesney-Lind 2002).

Since it costs more to contain and care for those relegated to spaces of state care, the political economy of punishment has transformed into a system of privatized management, including the pervasive privatization not only of services within the prison

like healthcare and vocational training, but also of the prisons themselves. Although many private companies make money off of building and sustaining prisons (2007), it has been long acknowledged that state-incurred costs of incarceration are a deterrent to the momentum of rising incarceration rates (Jacobson 2005; Wacquant 2002b), and that local economies benefit little from building prisons (Gilmore 2007). Rather than a retrenchment of the state through these systems of privatization, the financial contracts cast between the state and private companies as well as the delivery of services within state-regulated institutions has strengthened rather than diminished the power of the state to provide minimal measures of care for those excluded from the polis and the degree of authority it has over regulating that care.

The assemblages of cruelty, exclusion, rights, welfare, and punishment outlined in this historical formation of the modern carceral state have helped to make incarceration a persistent social and political phenomenon that, despite its “exceptional”⁵ nature, defines contemporary America. In order to give a firmer grasp of my ethnographic analysis of the ways care and custody constitute one another in the everyday provision of healthcare services at Graterford, I build on a body of anthropological literature that examines the enactment of care and its merging with punitive logics and structural displacement and dispossession (see especially Biehl 2005; Bourgois and Schonberg 2009; Garcia 2010). Such orientations alert us to the possibilities afforded by acts of care under conditions of oppression and the concomitant suffering and vulnerabilities that are often reproduced in them. As Lisa Stevenson writes, “Shifting our understanding of care away from its frequent associations with either good intentions, positive outcomes, or sentimental responses to suffering allows us to nuance the discourse on care so that both the ambivalence of our desires and the messiness of our attempts to care can come into view” (Stevenson 2014:3).

Throughout this dissertation, I show glimpses of nurturing care, care offered as a commodity, and care as a legal obligation. All of these forms of care contort and comeingle under the conditions of state custody, forging contradictions in citizenship, legitimacy, and recognition. The experience of incarceration is the experience of living at

the limit of suffering recognizable as such, forging a relationship with the state mitigated by the law.

Wards of the State

“Wards of the state” is a common moniker given to prisoners. This term has seemed to have fallen out of fashion in scholarly work, whether because it is seen to describe a relationship to the state based on the provision of services that is often precluded by incarceration’s ability to strip citizens of their rights or because of the increasing ways in which the carceral state is tied up in modes of economic production that create “consumers” of inmates who have to pay for state services rather than wards (see Aviram 2015). However, I find the term “ward” extremely useful in thinking about inmate identities as wards and the relationships they create to care while under the custody of the state, especially given that healthcare is a right for inmates that is inscribed in the Constitution – even if in name only. In fact, the word itself is derived from this relationship of care and its indexical relationship to control; its early etymology makes reference to being watched over and guarded over. It then came to take on meaning for this relationship of being in someone else’s care and custody because one was deemed unfit to care for oneself – the condition of being a ward. The physical space of a ward, as in a modern hospital ward, also bears this relationship of watchful control. Early uses of the term referred to castles and fortresses, and then it came to take on medical uses to describe the space of care for sick people in the 18th century.

Through traversing the scales of legal doctrine, privatized managed care, and collective historical memory, bringing them to life in personal narratives and individual clinical interactions, I make use of the double meaning of the word “ward” to advance the notion, first, that the physical space of the prison’s medical unit is a “ward of the state” – a space of care where the state is “made” through the interactions of individuals who relay the state’s investment in and regulation of inmate healthcare, while also enacting structural forms of marginalization and exclusion (see Fassin 2015). Despite being one of the few contexts in which a strong claim to healthcare can be made, the institutional structuring of prison healthcare is used to perpetuate forms of racial subjugation that reify inmates as criminals deserving of punishment. In the same way that ill people are

confined to hospital wards as a way of decreasing the spread of disease, inmates are relegated to and confined in these spaces of state care in order to isolate and control them and the mechanisms through which they are cared for (see Foucault 1975).

Applying the second meaning of “ward,” I argue that incarcerated men themselves are cast as “wards of the state,” relegated to the state’s custody and configured as its biological and financial property. As such, the state has an obligation to care for inmates as only partial citizens who are granted a right to healthcare in the contexts of rights deprivation as punishment for crimes committed. Rather than a full right to healthcare and access to citizenship through instances of medical claims-making or the demonstration of suffering, the relationship to care and custody that inmates have is one in which they are quasi-citizens, or to borrow Lerman and Weaver’s phrase for people formerly convicted or experiencing state surveillance in communities, “custodial citizens” (Lerman and Weaver 2014:112). The construction of inmates as property, consequently, represents the historical continuity of chattel slavery also encoded in the Constitution in the Thirteenth Amendment, which outlaws slavery “except as punishment for a crime.” As such, race is paramount in my analysis of contemporary prison healthcare. As I have outlined above, the system of imprisonment in the U.S. historically and the period of mass incarceration currently have been utilized in order to create “others” who do not belong to the citizenry. Utilizing the social label of criminal has allowed the perception that those who bear that mark are less than human. As an anthropologist, understanding the contexts that define humanity drives my inquiry into these systems of state care. “Wards of the state” allows me to elucidate the processes that reduce inmates to inhuman others, to those not deserving of care, to property.

As Dylan Rodríguez writes:

The specificity of imprisonment as a regime of power is its chattel logic, a structure of abject and nonhuman objectification. To the extent that the prisoner or inmate is conceived as the fungible property of the state (the Thirteenth Amendment designates the convict’s juridical eligibility for “involuntary servitude,” or enslavement), the captive is both the state’s abstracted legal obligation and its intimate bodily possession (Rodríguez 2006:12).

Being guaranteed a right to healthcare by virtue of being under state custody reproduces the structural personhood-as-property idiom for racialized institutional segregation, exploitation, and oppression while also allowing for a detailed analysis of the positive rights and structural potential imbedded within a legal obligation for the care of such an “intimate bodily possession.” Thus, through the notion of “wards of the state,” I am able to build upon a broader anthropological commitment to understanding the role of health in making claims to state belonging (Petryna 2002; Ticktin 2011) and the production and valuation of life itself in the context of structural isolation and vulnerability (see for example Biehl 2005; Fassin 2010).

Chapter Overview

In Chapter 1, I outline the functions of the right to healthcare that inmates were granted under the Eighth Amendment to the United States Constitution that protects them against “cruel and unusual punishment.” I describe, through legal history and inmate narratives, the process of judicialization of the inmate right to healthcare and then explore how traces of this right are seen in the prison clinic and are demonstrated in the experiences of inmates who must come to understand and navigate the contradictions inherent in such a right. I see the historical, political, racial, and economic construction of the right to healthcare not as a positive right granted by the state to health or healthcare access, per se, but as protection against “unnecessary harm” to those in its custody. These legal constructs help shape inmates as quasi-citizen wards of the state.

Chapter 2 describes how the capitalist logics of managed care entered into the prison through the privatization of healthcare services. Initiated out of legal necessity and discursively merged with notions of “doing good,” marking a form of humanitarian capitalism. Although it was difficult for private healthcare companies to make profits by rationing inmate healthcare, the process of attempting to do so delayed care until inmates met the legal standards for treatment, and contributed to inmates’ fears of economic exploitation and experimentation. I also demonstrate how, just as easily as the logics of managed care entered the prison, they also leave, linking the prison to larger transnational systems of administrative regulation over health.

Understanding the merging of care with the gendering functions of the prison, Chapter 3 shows how masculinity placed inmates “at a loss” for care, even as incarceration itself forced a loss of masculine identity and civic masculinity. I examine regulations on inmate contact through the Prison Rape Elimination Act, the gendering of the medical gaze, and providers’ discursive attempts at demonstrating respect as all functioning to distance inmates from care. I end this chapter with a meditation on one inmate’s amputations and its implications for understanding loss and recuperation in the face of institutionalization.

Through an extended ethnographic vignette, Chapter 4 conveys how care in the context of a specific medical intervention – a flu vaccine clinic – was delivered in the prison’s Restrictive Housing Unit (RHU). I examine the politics of inmate vaccine refusal and acceptance, linking it to the condition of confinement and the construction of an atmosphere of mutual vulnerability. I demonstrate how the RHU specifically exacerbates the structural limitations of custody on the enactment of compassionate and supportive care while also highlighting how much potential medicine and care has in such a symbolically and structurally oppressive place.

Finally, I examine three inmates’ struggles for justice in the context of serving life sentences in prison in Chapter 5. With Derrida’s notion of justice *à venir* (yet to come) and Kafka’s figure of the man from the country waiting before the law in mind, I consider how these men are made to wait for justice, and how they come to inhabit justice in the process.

¹ *Salvatore Chimenti et al. v. PA DOC et al.*, E.D. Pa. [2015].

² Michael Ollove, “Are States Obligated to Provide Expensive Hepatitis C Drugs?” *The Pew Charitable Trust*, February 9, 2016, <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/02/09/are-states-obligated-to-provide-expensive-hepatitis-c-drugs>

³ Specifically, the clinical criteria for treatment with Harvoni required the following:

- A Child-Turcotte-Pugh (CTP) score of 7-9, which is equivalent to CTP Class B disease, with a 57% two-year survival rate (Cholongitas et al. 2005).
- Decompensated cirrhosis of the liver
- Evidence of esophageal varices, dilated blood vessels in the esophagus with a high rate of disastrous bleeding that occur as a consequence of diminished blood flow through the liver and high venous pressure.

⁴ See, for example, Lara Bazelon, “Pennsylvania’s Shame,” *Slate*, Oct. 12, 2016, http://www.slate.com/articles/news_and_politics/jurisprudence/2016/10/how_did_pennsylvania_s_criminal_justice_system_fail_this_profoundly.html

⁵ Here, I rely on Giorgio Agamben’s (Agamben 2005) description of sovereignty as the ability to invoke a “state of exception” in which the rules are suspended in order to create rules anew. Agamben describes this irony in viewing the “exceptional” nature of modern states, which is primarily created and then sustained by those states’ abilities to enact “exceptions.” Agamben therefore sees the state of exception as the paradigm for modern governance.

Chapter 1 – Cruel but Not Unusual

Nobody promised them a rose garden.

– Justice William Rehnquist, *Atiyeh v. Capps*, 449 U.S. 1312 (1981)

Why “Where” Matters

The prison’s dispensary was in many ways the functional and activity hub of the medical unit, and it served multiple purposes – emergency room, pharmacy, procedure room, general consultation area, and a social spot for the providers to congregate. It was also where inmates coming from outside appointments and court dates would visit upon returning so the staff could document if there were injuries sustained outside the prison, gather any discharge instructions from outside healthcare providers, and ask the inmate if any adverse outcomes at court had caused him to want to hurt himself or anyone else. The dispensary was a rather small room with one gurney pushed to the side, dividing the area in two; the area behind the gurney was where the covering provider would stand, and the area in front is where the nurse would sit, closer to the medicines and supplies. The gurney sat just behind the tracks for a privacy curtain, which usually remained tucked behind a filing cabinet.

Toward the entrance were a filing cabinet with catalogued medicines and a chair where an officer usually sat in the afternoons with a telephone nearby. The walls were lined with cabinets containing suture materials, bandages, splints, catheters, and other medical paraphernalia. The counters had a few older reference books since there was no outside internet connection and first-aid materials, along with two computers to access the medication review and ordering system. On the nurse’s side there was also a small port to the medical records room, through which paper charts for patients were passed. Pushed up against the wall in the far corner lay an EKG machine and a defibrillator device, and in the other corner stood a chair for inmates to sit in. Although the material space of the dispensary itself was not immediately recognizable or distinguishable as belonging to a prison, the ways it was inhabited held constant reminders of the prison

setting, from the physical components of slamming doors, clanking chains, and the occasional bleep of a walkie-talkie to interactional dynamics where qualifications were placed on patients' entitlements to care and their own bodies. These moments served as reminders for how much the institutional setting influenced care – why “where” mattered.

One of my afternoons in the dispensary early on in my fieldwork brought these dynamics directly to the fore. Typically, an officer from elsewhere in the prison would call the dispensary phone to have a nurse assist in triage, to inform them to prepare for an emergency, or ask them for assistance in medical transport. This afternoon we received a call from the Mental Health Unit (MHU) that an inmate, Mr. Leonard, had swallowed some pills and glass in a suicide attempt. Three officers escorted him up to the dispensary where he sat in the chair, hands shackled through a belt around his waist. Tim was the nurse on the afternoon shift. A short, middle-aged white man with a moustache and hair dyed a flat shade of brown, Tim had been working at Graterford for almost a decade. He had a gentle demeanor but could quickly turn assertive. He began to interview Mr. Leonard and the officers, trying to get a clearer picture of the events, and Mr. Leonard grew candid about his intentions:

Tim: [*Looking around at officers*] Did anybody see him swallow ‘em? [*Looking to Mr. Leonard*] Did you swallow pills?

Mr. Leonard: I swallowed Tylenol, Ibuprofen, and glass, man. We ain’t lyin’. This is not no game. It’s not my first time doing it. It’s *gonna be* the last time. That should be destroying my liver this time. I ingested, OD’ed two months ago. My liver shut down on me. I was in the ICU for three days. They gave me some medicine that I guess helped my liver come back, but... No.

Tim looked to Dede, a slender African immigrant fresh out of nursing school in Philadelphia and the nurse practitioner staffing the dispensary. He asked her if she was hearing Mr. Leonard’s responses. Dede nodded while she began looking up his medications on the computer and preparing her note for the chart. She asked if there were any witnesses to corroborate his story.

Correctional Officer 1: Yeah, we were standing at the cell door.

Dede: How many did he swallow?

Correctional Officer 1: Hard to tell. It was...

Correctional Officer 2: They were all crushed already. They were in powder form.

Mr. Leonard: Thirty were crushed. Thirty were in pill form. Everybody seen 'em.

After Tim documented the amount of medication Mr. Leonard had taken, plans were made to arrange for him to be sent to an outside hospital to have his stomach pumped. Dede was asked to make a decision about whether Mr. Leonard should be transported by prison vehicle or ambulance, a decision influenced by both time and cost. The prison van would take longer, typically 20 to 30 minutes before they could round up the COs to escort and take the inmate through processing to the van. The van was also considerably cheaper. Besides labor, gas, and occasionally overtime (sometimes care was even delayed until just before change of shift so an officer could collect overtime or just after to recruit the incoming officer), the van was free. After determining from the officers and Mr. Leonard that it had been over thirty minutes since he ingested the medication, she opted for the ambulance. Some conversations then began to take place in the background amongst the medical staff, wondering how he could have accessed the medications in a unit that is supposed to be secure. The idea that he had undermined the imaginary of the prison as an absolutely secure place where all human activity could be controlled, which the prison staff knew was false in practice, broke open a host of considerations. Suddenly the providers began discussing how they should best fulfill their legal obligation to treat Mr. Leonard and how this obligation became entwined with financial considerations, and the coordinated labor of the correctional and healthcare staff.

The video camera aimed at Mr. Leonard to record the incident¹ was turned off when one officer conveyed to a lieutenant that there was “no use of force” and “the inmate was cooperative.” All the while Mr. Leonard, a black man in his forties with short, patchy hair and high, pronounced cheekbones, sat in the corner chair with a cool

nonchalance I would not have imagined for someone expecting to die. He acted casually and responded calmly despite the chaos of all of the staff running circles around him, asking him questions and carrying on side conversations. After the camera was turned off, a black, female sergeant entered the room and began discussing Mr. Leonard's suicidal ideation with him in a way that brought out how his suicide attempt and the experience of incarceration informed each other:

Mr. Leonard: I was gonna die February 20th if I didn't let them administer that medicine. I took 82 and my whole liver just shut down, literally. I bet you I don't come back.

Sergeant: I bet you you do. Then what happens when you come back?

Mr. Leonard: [*shrugs*] The effects are already taking hold. My liver's destroyed already. This time I'm going to finish the rest. You think I'm joking? They had me wrapped up like a mummy last time in the ICU.

Sergeant: Ok, well, guess where you are now. Graterworld – carceral capital of the world! You don't do that here.

Mr. Leonard: This way you've got one less person you'll have to worry about.

Sergeant: [referring to a conversation the two had days prior about the movie *Passion of the Christ*] If you watch *The Passion* then you know what it means to kill yourself. Why would you want to do that?

Mr. Leonard: Because. What do I gotta live for?

Sergeant: After everything, why don't you deserve life? How do you figure?

Mr. Leonard: I just don't deserve it. I did 20 years of my life in here, I haven't done meaningful things in my life. So I want it to be over.

Sergeant: That's not up to you.

Mr. Leonard: Yes it is!
[...]

Sergeant: I don't understand, then. Why do this? Don't you have family?

Mr. Leonard: My mother died at 48.

Sergeant: Who do you have?

Mr. Leonard: I have my two boys. They're on their own.

Sergeant: So how do you think they will feel?

Mr. Leonard: I'm not saying they're not gonna be hurt.

Sergeant: They're gonna be more than hurt.

Mr. Leonard: I spent a lot of my years away from my kids. Downstairs you've seen me in tears. Literally, it may be the coward's way. It may be me being selfish. Whatever you want to call it. I'm gonna be... done though. I'm gonna be finished with worrying about everybody from the inside. You know when shit gets on all the time, you can't control what's going on at the house. You gotta stop worrying about it. I been in one of the most racial [marked by racism] prisons in New York State...

Sergeant: It doesn't matter where you are. It doesn't. I firmly believe that.

I stood there beside Mr. Leonard, overcome with what was being said and trying to quell my shock and confusion. I was surprised that the sergeant would so easily – and with such aplomb – refute the links Mr. Leonard was drawing between his incarceration, experiences of racism, and the state in which he then found himself. In the first part of their conversation she had even stated how important “where he is” matters to their custodianship of him and the limitations placed on his freedom. The sergeant ultimately seemed to be claiming that inmates could have meaningful and fulfilling familial relationships while incarcerated and avoid depression and hopelessness, yet they could not – or did not – have control over their bodies or what kinds of medical attention they could seek. The sergeant couched the denial of control and working toward having a meaningful life in prison in a language of “deserving life,” presumably for life's sake. Mr. Leonard, on the other hand, seemed to be stating that incarceration, separation from his family, and being the object of racial animosity had led to his hopelessness – to being labeled *undeserving* – and was now infringing on his ability to deserve the life of his choosing. In both constructions, the “where” of the prison was a key reference point in framing “deserving life.”

Meanwhile, Dede remained along the wall still anxiously looking through Mr. Leonard's chart and his medications to determine his health status and whether he was prescribed the Tylenol and had been hoarding it. She called me over, quickly shifting my attention and the tone of conversation to focus on medical accountability: "I should see if we have a recent [liver] panel on him so we could know now what kind of damage is done to the liver," she whispered to me. Then, either blaming the psychiatry staff for the suicide attempt or claiming that handling the attempt was their responsibility, Dede mumbled, "This is totally psych. He's not on Tylenol. Or he was, but it should have expired. ... It's just ridiculous." Her exasperation was a reflection of her inability both to control what Mr. Leonard had done but also to bureaucratically manage a patient that belonged to a separate staff of mental healthcare providers.

After the ambulance came and took Mr. Leonard to the hospital, a whirlwind of accusations was stirred up, and a vigorous debate ensued about who was to blame, bringing in nurses and supervisors from throughout the unit. Dede exclaimed, "That's the least psych can do is watch their patients!" Some argued that it should have been impossible for him to have access to those medications and to hoard them for that long, all outside of the officers' and the nurses' supervision: "Don't they do DOTS [directly observed treatment] down there?" "The guards must've been slipping them to him! It's the only way," shouted one nurse. Then the accusations landed on Mr. Leonard, raising suspicion about the veracity of his attempt. "I don't believe him," said another nurse matter-of-factly. "He wants to take a walk.² The officers saw him. Why else would he do it?" Tim countered, "He said he wanted to die," which invited a comment from another nurse about how if he were attempting a hoax, he could expect retaliation from the officers: "If he doesn't die, he'll wish he had."

All of these accusations refigured the sergeant's commentary about how Mr. Leonard's environment and his status as an inmate dictated what medical attention he could seek. They implied that the prison's custodial and security obligations were paramount, and that Mr. Leonard's care seeking could only be motivated by manipulation – either manipulation of the mental health staff so that he could hide and take drugs or manipulation of the medical staff to fake a suicide attempt in order to cost the prison

money and take a ride in an ambulance. This led Dede, in a prescient moment, to reflect on the larger context of Mr. Leonard's case once the medical management she had previously been preoccupied with was less urgent. She began to question the rules around Mr. Leonard's consent to be sent out if he were truly suicidal and how his environment informed their obligations: "What if he wasn't here? There might not be the same intervention. Is that our responsibility?" As if the medical management were not difficult enough for her, the additional unique ethical considerations Dede faced as a result of the prison's charge to care for and contain inmates left her slightly overwhelmed. "It's just so complicated here," she said with a sigh. "This is not the best place for accountability."

Just then Dr. Keller, the prison's medical director, came into the dispensary to announce that when Mr. Leonard arrived at the outside hospital he was refusing treatment, and the hospital was honoring that refusal: "I just got a call from the Emergency Department. He's refusing treatment and wants to sign out, so they won't treat him." Struck with sense that he might actually be able to refuse treatment, as many people often do in community hospitals when they leave against medical advice, the atmosphere of the room suddenly changed. The blame placed on Mr. Leonard for his disobedient suicide attempt abruptly shifted to the Emergency Department, and Mr. Leonard became a passive actor in the scenario in a refusal to acknowledge that he might be able to refuse. The providers now became concerned that their decision for treatment was not being honored, and that they may have therefore incurred the cost of an ambulance ride to send Mr. Leonard out "unnecessarily."³

This concern manifested in the assertion that Mr. Leonard – as an inmate – did not, in fact, have the right to refuse medical care. Tim shouted out, "That's bullshit! He can't refuse care! That'd be like the state assisting in his suicide!" Dr. Keller echoed this statement with some clarification based on his previous experience working for the Philadelphia County jails: "I was trained in Philly that they're wards of the state, and they don't have the right to refuse treatment while they're here [in prison]. But once they're there [at an outside hospital], then they can refuse and sign out against medical advice, no problem. That's just how I was trained." Hearing this, I began to share the confusion expressed by Dede and Tim about the circumstances under which an inmate had the right

to refusal. In other circumstances I had seen inmates refuse treatment without question; in fact, especially when it came to uncomfortable procedures like rectal exams or tests that were either seen as unnecessary or could be postponed, providers sometimes encouraged inmates to sign refusal forms. I used this opportunity to pose the question to everyone if inmates generally had the option of refusing treatment. Tim responded, highlighting an important limitation to Mr. Leonard's right: "On some things, yes. I guess it's possible you can refuse on some things, but not on life sustaining treatments."

This scene raises questions – as it did for everyone in the dispensary that day, amidst all the accusations of blame – about the healthcare rights that inmates have by virtue of their incarceration, and what these rights both permit and prevent. It offers the opportunity that I take up in this chapter to ask precisely how “where you are” matters, because in this instance where you are dictates who you are before the law and the state. For Mr. Leonard, being an inmate imposed a precise limit on his right to bodily authority that disappeared when he left the institution and the prison would no longer be responsible for his potential death, owing to the prison's precise role of custodianship and maintaining legal liability over life. In this sense the outside hospital could recognize any right that Mr. Leonard had to refuse care, but the prison could not do the same and expect to remain free of legal scrutiny. Furthermore, the specific forms that care took within the confines of that limit were shaped by the everyday functions of the prison in terms of security (maintaining strict access to medications and suggesting retaliation for a hoax) and custody (maintaining isolation and assuming legal and financial responsibilities of treatment).

Focusing on where (i.e. prison) and who (i.e. inmates) rather than what (i.e. crime) when it comes to health rights helps draw a conceptual counterpoint to the juridical and common sense linkages examined in this chapter that have justified rights deprivation during incarceration as punishment for crime. Incarceration, not crime, is the fundamental quality determining what rights inmates have and do not have. There is no differential scheme of rights afforded to incarcerated people that is determined by the severity of crime; nor, for that matter, are all those who are convicted of crimes guilty of having committed them, yet they are incarcerated all the same.⁴ There is no mention of

Mr. Leonard's criminal behavior as justification for the schemes of rights and "deserving life" (or lack thereof) that circumscribed his experience, only a reference to institutionalization and the conditions of incarceration. Criminality is assumed, and the accompanying restrictions on rights are displaced onto the institution. Accordingly, I ask: How has the development of prisoners' rights defined the obligations for care and inmates' relationship to the state? What are the ways the legal constructions of rights become superimposed on clinical encounters? How does being becoming a "ward of the state" influence inmates' experiences of care and custody, affecting their authority to make claims to matters of health as fundamental as life and death?

With these questions in mind, this chapter takes both a synchronic and diachronic view of inmates' health rights in order to outline the politicization of the health and life of inmates and to show how its contours become evident in the prison clinic and the ways inmates think about their health and their relationship to the state. I first plot the social and cultural configuration of inmates' right to healthcare in case law, and then show how traces of this right emerge in the prison clinic and are reflected in the lives and experiences of inmates who must come to understand and navigate the contradictions inherent in such a right. The historical, political, racial, and economic construction of the right to healthcare is not, in fact, a positive right to health or healthcare, but a protection against "unnecessary harm" to those in its custody, with a focus on avoiding legal culpability for death. This configuration assures the legal and practical conflation of care and custody in the prison, and in turn affects inmates' conceptions of themselves as rights-bearing individuals and their ability to access both healthcare and the law as "wards of the state."

Drawing Back the Iron Curtain

The period from roughly the 1960s through the 1980s known as the prisoners' rights movement encompasses a series of broad political activities around the liberation of prisoners and the reform of brutal and inhumane prison practices. Many contend that the most enduring and significant result of this movement, specifically in its designation as a movement about *rights*, was the recognition that inmates could have legitimate constitutional claims. In this view, myriad political tactics and ideologies were channeled

through courts to achieve legal victories that improved prison conditions.⁵ Sociologist and legal scholar James Jacobs draws a parallel to civil and women's rights movements to assert that although there was much more widespread sociopolitical action within the context of a long history of prison reform efforts, the prisoners' rights movement became crystallized in landmark court cases that recognized the legal personhood of inmates: "The precondition for the emergence of a prisoners' rights movement in the United States was the recognition by the federal courts that prisoners are *persons* with cognizable constitutional rights" (1980).

In a 1974 landmark case, *Wolff v. McDonnell* granted inmates procedural protections in disciplinary hearings. Supreme Court Justice Byron White wrote the following delivering the opinion of the Court: "[T]hough his rights may be diminished by the needs and exigencies of the institutional environment, a prisoner is not wholly stripped of constitutional protections when he is imprisoned for crime. There is no iron curtain drawn between the Constitution and the prisons of this country."⁶ These words secured the link between the cellblock and the courtroom, helping to ensure the legal system as the primary avenue inmates have for substantive engagement with the state and reflexively projecting the state's presence in the prison through the law. This created a counterintuitive scenario in which the same justice system that convicted inmates and could "diminish" their rights "by the needs and exigencies of the institutional environment" became the principal means to ensure the protection of those rights, resulting in what was actually a rather precarious recognition of inmates as "persons" before the law.

When it comes to healthcare, drawing back the iron curtain separating prisoners from the Constitution revealed what philosopher Jacques Derrida calls the "mystical foundations of authority" in the law, shedding light on the shadows and blurred edges between the state's punitive and protective functions – that violence and the law constitute one another (Derrida 1992). Among the cases considered part of the prisoner's rights movement that extended specific constitutional claims to inmates after *Wolff v. McDonnell*, was the 1976 case *Estelle v. Gamble*. In *Estelle*, the Supreme Court decided that "deliberate indifference" to the "serious medical needs" of prisoners violated the

Eighth Amendment to the U.S. Constitution, which protects against “cruel and unusual punishment.” The legal legacy tying inmate healthcare to the Eighth Amendment places inmate healthcare squarely within the protective and harmful dimensions of state power. It offers protection, granted by the state, against an excessive degree of harm to those in its custody. In this way healthcare became a negative right (i.e. one that specifies what counts as allowable suffering at the hands of the state’s healthcare providers) rather than a positive right of systematic access to healthcare services.⁷ These conditions clearly define the limits of the right to healthcare. The state sets the conditions of acceptable harm it can impose through a right to be free from excessive punishment, ironically recognizing the state’s own sovereign power to enact harm while also creating the conditions for hope of protection from harm.⁸ In Mr. Leonard’s case above, his right to be free from harm did little to protect him from reaching the point of suicidality, yet intervened when the harm became recognizable as a threat to his life – and, by extension, the threat of the institution to adequately prevent his death.

The fact that the Eighth Amendment served as the most useful entry point into the legal system at a time when prison conditions were being hotly contested both in the courtroom and on the cellblock speaks to the inability to separate the punitive and caring functions of the prison. It was and continues to be more socially acceptable to argue for a limit to the harm that the state could impose as a method of punishment than to grant a wholesale right to healthcare. Linking healthcare to that limit made it part of the legal discourse on punishment rather than prisoners’ rights. Philip Genty (1996) along with other legal scholars has argued that healthcare provision for inmates more appropriately falls under due process and that a claim to unnecessary harm was a legally convenient one that drew on prison conditions litigation.⁹ Thus, an action surrounding an inmate’s health could only become “cruel and unusual” when it exceeded a limit of acceptability. This line of argumentation may have made sense for prison conditions that were expected to restrict freedom and comfort, but created a different set of meanings when applied to healthcare delivery. Here the standard of “cruel and unusual” implied that certain levels of suffering were tolerable and the points of intervention on suffering could be evaluated based on the malicious intent of the provider rather than the promotion of health. The

legacy created in tying the Eighth Amendment to health rights has therefore profoundly shaped the forms that inmates' healthcare rights can take and has led to the legal – and, in turn, practical – conflation of care and custody. In this way, the care that inmates receive becomes understandable only in terms of the larger conditions of confinement and the operations of the prison more systemically.

There were, however, three positive provisions guaranteed under the *Estelle* ruling. The first provision is equal access to a healthcare provider, which gives prisoners the right to see a physician in a timely manner (including same-day emergency treatment), and access to specialty and inpatient care. Importantly, under the equal access provision, inmates must be provided care for a “serious” medical condition. A “serious” condition has been defined and cited in subsequent federal court cases as one “diagnosed by a physician as mandating treatment or one that is so obvious a lay person would easily recognize the necessity for doctor’s attention”¹⁰ or “a condition of urgency, one that may produce death, degeneration, or extreme pain,”¹¹ designations which become important in considering how medical resources are managed in practice to avoid legal culpability for the death of an inmate. The second provision is “ordered care,” which refers to the mandate that other prison administrative and custodial officials comply with a healthcare professional’s orders, extending liability to staff who may interfere with those orders. The final provision is professional judgment, which grants correctional healthcare professionals the authority to determine the necessity and appropriateness of medical intervention and requires a secondary medical expert opinion in case the former is questionable. This guarantee also explicitly refers to the inability of the courts to determine what constitutes “good” medical care, allowing them to exercise judicial restraint when asked to make specific determinations on a claim that prison officials acted a certain way to maintain the security or financial administration of the institution (Rold 2008).

Evident from these guarantees is both how rudimentary the provisions are and how much is left up to the interpretation of individual actors within the institution to determine the contours of care delivery in response to an inmate’s claim. In an extension of that logic, individuals are primarily held liable for poor care only if they intend to

cause harm, not if they fail to provide needed treatment. Since *Estelle*, Eighth Amendment claims have been evaluated based on a two-pronged approach to “cruel and unusual punishment”: an objective, outcome-based determination of harm and a subjective determination of malicious intent, or “deliberate indifference.” The burden of proving deliberate indifference has overtaken the outcome-based prong in Supreme Court rulings, leaving the assessment of ill effects to civil claims of negligence and malpractice. Even in two notable cases where the Court upheld the inmates’ Eighth Amendment health claims, *Helling v. McKinney* and *Erickson v. Pardus*, such was done only on the basis of a known threat posed to their lives that was dismissed by the healthcare staff.¹² The judicial interpretation in these cases was still focused on intent rather than the demonstration of harm, stating that the risks to the inmates’ lives were known, and thus the inmate-plaintiffs were knowingly subjected to those risks. In this way, the judiciary remains agnostic with respect to a claim of negligence or malpractice even when harm is demonstrated,¹³ and only threats to someone’s safety that are known (and can be proven to be known) or the most vindictive actions are held under the level of legal scrutiny that actually grants inmates the right to healthcare. The perpetuation of these standards again highlights the power the state holds in marking the distinction between promoting health and protecting from harm.

In the midst of situations like those at Graterford and all Pennsylvania prisons, where there has been an increased reliance on private, for-profit vendors to provide many of the state’s services in the prison short of the wholesale privatization of its facilities and correctional staff,¹⁴ it is tempting to see the growing irrelevance of the state in the governance of inmate health. However, the history of prison health litigation and the prisoners’ rights movement has placed prisons in close proximity to the law, securing the salience of state sovereignty as the critical structural force shaping inmates’ health through the Constitution. Private healthcare vendors like those operating at Graterford can still be sued under federal law and are therefore susceptible to claims that inmates’ constitutional rights have been violated. In working in the capacity of a contract with the state, they are considered to be acting “under color of state law.”¹⁵ This means that privatization is by no means a method of escaping legal liability or eclipsing state power,

though I demonstrate ways that rights are complicated by privatization here and in Chapter 2. Rather than outsourcing the oversight rights provision to corporations or other organizations, the state maintains the ultimate authority over rights through the determination of legality. Therefore, state sovereignty is not weakened in the presence of other non-state techniques of governance, but is transformed by and merges with them (see e.g. Hansen and Stepputat 2006; Sassen 1996; Sharma and Gupta 2006). The importance of the merging of different structural forces in the context of state sovereignty over inmate health becomes apparent when the judiciary defers to prison administrators and the “necessary operations” of the facility to determine whether something is “cruel and unusual” and therefore violates constitutional rights. As Mr. Leonard’s suicide attempt clarified for all those in the room, facilities could operate under multiple logics – cost efficiency, securitization, empathic pleas to the worth of life, and the systematic devaluing of life – without ceding authority of the state to perpetuate the links between punishment and protection.

One well-known example in the case law that demonstrates the judiciary’s deference to institutions, the primacy of intent, and the conflation of care and custody is the 1995 case *Madrid v. Gomez*. In *Madrid* a Federal District Court in California considered the constitutionality of the health effects of solitary confinement in supermax cells at California’s Pelican Bay facility. The court decided that the level of isolation and sensory deprivation that went along with being on lockdown for 23 hours out of the day, confined to an 8x10 cell with fluorescent lighting was only unconstitutional for inmates with previously recorded mental illness. Even though the court itself described conditions at Pelican Bay as “wretched misery,” it stated that the record did not sustain the allegations advanced by the plaintiffs, which included all inmates housed there.¹⁶ Thus, they found that it was entirely constitutional to house inmates there in “administrative custody” as a form of punishment because staff had determined they posed a threat to the security of the prison. In the same decision, the court states:

Throughout these proceedings, we have been acutely sensitive to the fact that our role in Eighth Amendment litigation is a limited one. Federal courts are not instruments for prison reform, and federal judges are not prison administrators.

[...] At the same time, we have no duty more important than that of enforcing constitutional rights, no matter how unpopular the cause or powerless the plaintiff.¹⁷

This disclaimer clearly highlights the court's strategic decision to exercise judicial restraint and to normalize the ideology of punishment under the illusion of federal protection, despite the fact that legal claims are the only ways such protection is afforded.¹⁸ In this rhetorical sleight of hand, any ideological commitment to the rights of inmates based on benevolence is overtaken by legal doctrine, reiterating that inmates' health status is susceptible to the caprice of the state and that illness and harm must rise to the level of being "repugnant to the conscience of mankind"¹⁹ before becoming legally – and therefore clinically – visible.

In a 1981 decision on a case alleging cruel and unusual punishment for prison overcrowding, Judge Rehnquist highlighted just how little is afforded by the Eighth Amendment. His statement reiterates the ambivalent nature of inmates' rights and their legal inseparability with punishment:

Nobody promised them a rose garden; and I know of nothing in the Eighth Amendment which requires that they be housed in a manner most pleasing to them, or considered even by most knowledgeable penal authorities to be likely to avoid confrontations, psychological depression, and the like. They have been convicted of crime, and there is nothing in the Constitution which forbids their being penalized as a result of that conviction.²⁰

Juxtaposing this decision with the scene of Mr. Leonard's suicide attempt reveals the stark contrast between legal discourse meant to uphold punishment through the denial of a form of incarceration "most pleasing" to inmates and the reality faced by those whose lack of care can have such tragic consequences. Mr. Leonard was not promised a rose garden, indeed.

If inmates were to be recognized as potential rights-bearing persons, healthcare during incarceration was considered a necessary function of the state – so necessary that the law was charged with protecting it, but without forbidding penalization. Granting a full right to healthcare was so threatening to the ideological commitment to punishment,

especially since such a right was (and is) not a guarantee for the rest of the American population, that poor health was forced to rise to the spectacle of being “cruel and unusual punishment.” In this way, prison healthcare laws (as well as prisons generally) are a “projection of national sovereignty” (Bosworth et al. 2016:4) not through practices of total exclusion from state functions and social abandonment, but through very active investment in the construction of specific yet contradictory rights. Recognizing inmates’ vulnerability to state power, the state saw fit to assure them a right to healthcare that at a minimum protected against its own cruelty. Creating a law that inscribes inmates as “wards of the state,” vulnerable to and protected from the same entity, engendered a situation where seeking liberation from that condition was structurally impossible, therefore limiting political praxis and legal personhood that might allow inmates to seek freedom from state power.²¹

In the *Estelle* ruling, the Supreme Court made prison inmates the only group in the United States with a constitutional right to healthcare. Yet the contemporary context of incarceration easily revokes and redefines rights, and punishment, rather than care, is the prison’s *modus operandi*. Therefore, the only way one can begin to understand inmates’ right to healthcare is to also understand how rights have historically been weakened by punishment as well as how race functions as a contemporaneous form of exclusion from protective rights. In fact, the Thirteenth Amendment abolishes slavery and involuntary servitude “except as punishment for a crime,” making inmates the only population that can also be enslaved, a condition that legally inscribes them as state property and revokes the supposed inalienability of their civil rights (see also Dayan 2002; James 2005).

There is thus a clear tension between these two distinguishing legal (indeed, Constitutional) features of incarceration – the only population with both a state-granted right to healthcare and the ability to be completely subjugated by the state – whose hybridity becomes embodied in the “ward of the state” designation. This term conveys the relationship of belonging to the state in a relationship of vulnerability, care and custody, elaborated in the *Estelle* ruling itself. *Estelle* cites an earlier precedent that “it is but just that the public be required to care for the prisoner, who cannot by reason of the

deprivation of his liberty, care for himself,”²² which became reflected in both inmates’ and providers’ articulations of the legal obligation to care for inmates as wards described below. Drawing back the iron curtain between inmates and the Constitution during the prisoners’ rights movement was presumed to have reversed the prior legal status of the prisoner as a “slave of the state” who “has as a consequence of his crime, not only forfeited his liberty, but all his personal rights except those which the law in its humanity accords to him.”²³ Instead, it ushered in a situation where inmates paradoxically rely on the state to care for them by virtue of its legal obligation, and they also rely on their vulnerability and suffering under the state’s care to make claims to the state to restore their rights

The Judicialization of Inmate Health Politics

The structural legacy of state governance of prison healthcare through the legal discourse of rights constructed the social field in which health politics at Graterford took place. Inmates conveyed the condition of being subject both to the state’s custody and to its judiciary procedures to contest the features of that custody that made or kept them sick, mentioning the desire to hold the state accountable in ways the state recognized as legitimate. In contrast, political protests (e.g. staged collective strikes or riots) were not seen as viable methods for either improving the delivery of healthcare or asserting inmates’ humanity, despite the vital role they had in the early judicial recognition of inmates’ rights. In fact, inmates commented that these political tactics only served to further impinge upon their rights, expose them to violence, and exacerbate the dehumanizing aspects of incarceration.

Despite commenting that prison protests “here and across the globe have always been over two major things: food and healthcare,” inmates claimed that an effective means of holding the state accountable to provide sufficient medical care could not involve organized protests, but must instead involve some component of legal intervention, if not a full-fledged lawsuit. Inmates discussed having to “play the game” of working within the legal structure that was set out in the wake of the prisoners’ rights movement. They mentioned having to be patient, exhausting administrative grievances to “start low and go all the way up the ladder to the feds.” The impracticality of political

protest in this bureaucratic and legal context is evidenced in part by what transpired on Graterford's A Block one summer, in the only act of protest that occurred during my fieldwork.

In mid July, a group of inmates on A Block, which housed many men who had been incarcerated for decades, most of whom were serving life sentences, staged a protest against the rationing of already inadequate and substandard food, inadequate medical care, and other grievances with the prison administration. They were partially inspired by a similar protest at SCI Coal Township, a prison in central Pennsylvania, which took place a few weeks prior. At Coal Township over 1,000 inmates engaged in a weeklong peaceful protest of the prison dining hall and delivered a list of demands to the prison administration, including: positive changes in medical care; allowing inmates to purchase nutritive foods through commissary and have foods mailed in by family members; a review of solitary confinement practices; and an end to economic exploitation in telephone, medical, and visiting room charges.²⁴ In the words of one of the inmates at Coal Township, the protests went “far beyond recent menu changes,” and sought to “assert [inmates’] rights as human beings deserving of humane treatment” and “build a massive movement to end this insanity, [requiring] outside and inside coming together.”²⁵ In response, the prison administration sent 17 inmates to the RHU and transferred 3 men deemed to be organizers of the protest to other institutions in retaliation for “unauthorized group activity.”²⁶

After refusing their lunch, the inmates on A Block at Graterford stood outside their cells and would not enter when the guards called for them to do so, citing their issues with the quality and quantity of the food they had been served and listing their medical and administrative grievances. The block was forcibly locked down and there was a search of each inmate's cell for contraband. A few inmates were charged with misconducts for “unauthorized group activity” and “refusing to obey an order” and placed in the RHU.²⁷ The following day as I walked down the main corridor, a CO walked by me, and I overheard him mentioning to another officer that the prison was on lockdown: “Yesterday A Block had some bullshit protest and now this!” After the search of A Block the day prior, they brought in an independent Correctional Emergency

Response Team (CERT) to search C Block in a display of authority meant to intimidate inmates and quash any future attempts at protests.²⁸ A discussion of the protest in the dispensary led Lance, a white physician assistant who was in his 50s and came to Graterford straight after school in a late-in-life career change, to comment: “They should be lucky it’s not like before when prison was prison. Now it’s like vacation!” reiterating a common belief among medical providers that inmates relish being in prison because “they know they’ll be taken care of” and they get “two hots and a cot.”

None of the medical staff, however, mentioned or seemed concerned about the inmates’ grievances against medical services or how they may have been related to issues of food and nutrition. Lance’s comment only demeaned any claims they could make by asserting that the prisoners were now too comfortable as a result of their rights, disregarding the fact that as he spoke, inmates’ belongings were being destroyed and their living quarters invaded by a tactical military operations unit. Furthermore, in his nostalgia for the days when “prison was prison,” he did not consider that many of the lawsuits and political activism of the prisoners’ rights movement produced court orders for increased staff, creating jobs for mid-level healthcare providers like him looking for experience and good entry-level salaries.²⁹ Medical and correctional staff remained unfazed by the protest, marking it as at best a trivial annoyance in their own workdays as they carried on as if it were not happening. At worst the protest served as an opportunity to justify the further criminalization and punishment of the inmates, especially through officers’ imputation of misconduct charges. Redirecting political action to courtrooms not only narrowed the forms it could take and made outright protest largely inconsequential to the institutional actors it was directed against, but it also brought the violence of the law into acts of protest, making it so that peacefully asserting a right to health could be seen as a criminal act.

The incarceration and political history of one inmate, Eddie, a 64 year-old black man who had already served 42 years on his life sentence, reflects the transition from large-scale political protest to the reliance on courts and the ambivalent relationship it creates to the legal system. Eddie was a jovial man, who almost always had his white, crocheted kufi perched on top of his head. He had deep-set eyes and full cheeks

frequently pursed in a smile or drawn back as he would stammer over his words as he tried to get them out. We met infirmary of the prison's medical unit when we met, waiting for the company to review the requests for treatment of an unhealed infection from an ingrown toenail on his right leg, which ultimately had to be amputated. He was working on an appeal to his case, but he was unable to access his legal documents while he was housed in the infirmary, where he remained for almost a year until he underwent amputation and subsequent physical therapy and fitting with a prosthesis. On the day after the Graterford protest, he mentioned that he had been involved in a riot at Holmesburg Prison, a Philadelphia prison that closed in 1995 and was notorious for its derelict conditions and the mistreatment of inmates, including sexual assault, beatings, and medical experimentation.³⁰

Eddie recalled his involvement in the Holmesburg riot on July 4, 1970, which left 96 people injured, and related it to the current prevailing sentiment and the political climate, taking pride in his ability to read the situation:

I've got my finger on the pulse of the jail. You've got to know that right now today, there is tension about this food! I'm talking about, it's *thick*. I've been in a riot before personally. It don't serve nobody. For real. It don't serve nobody any good. Everybody loses, the convict and the authority. Everybody lose in a riot. I was in a riot down in Holmesburg, and guards got hurt, inmates got hurt, people and their families all outside lining the jail. They got the jail locked down, nobody knows if they loved one dead or alive. And I was there. I was in that, was one of those with family outside the jail worried about whether I was alive or dead. And people got all kinds of hurt. It's a traumatic thing. Don't nobody make out from it. [...]

Now you gotta be very careful even how you present [protest] to your own, uh... constituents. You gotta be very careful how you present it, and you gotta come up with a *whole plan*, and that's dangerous, because if they find out you the one with the plan, you gone. You know what I mean? Before, if I'm the one with the plan, and they find out that I was the so-called spearheader, and they get me out, somebody else will step right up. That's not the situation now. That's one thing that's changed.

Eddie's historical narrative details how the violence of riots has largely transformed into the violence of law, reifying inmates who participate in acts of protest into criminals. While Eddie claims riots are traumatic and dangerous – and thus give

cause to avoid having the present discontents boil over into something so serious – he also states that other forms of political protest have become dangerous because of their ability to be criminalized and their lack of a strong social backing. He reiterated this stance when Graterford did not take part in the prison strikes that emerged across over twenty states in September 2016 primarily in response to the low wage or unpaid labor of inmates as a “modern form of slavery,” during the 45th anniversary of the Attica Prison uprisings in New York.³¹ Instead of becoming fixed in the law, rights in the setting of incarceration became circumscribed by security and criminalization. In the movement toward increased rights provision, there was a concurrent trend in both the large-scale (and prison-specific) criminalization and/or psychiatric management of racial political protest (see also Davis 1971; Metzl 2009), systematically reformulating the legitimacy of claims against the state and the forms care might take in response to those claims.

Eddie continued his reflection, describing his racial politics and how they articulate with his rights both as an inmate and a black man, drawing further connections to the transformation of inmate politics. Eddie joined the Nation of Islam in prison, which was common for inmates when he was first incarcerated in the 1970s. The Nation of Islam’s political activities helped educate and recruit black inmates to build solidarity for black liberation in the years prior to the prisoners’ rights movement (Berger 2014), and they continue to have a strong presence in contemporary prisons. Eddie, who said when he was first incarcerated, “I wouldn’t have even talked to you,” because “back then everything was black and white to me,” described the duality of racial consciousness in the civil rights era and the contrast between solidarity and state-issued rights, drawing a direct parallel to the provision of healthcare in prison:

Eddie: That’s how I grew up, and that’s how I got to know about the two societies in the United States of America, one black and one white. Just like all the rest of ‘em at first I was mad, angry... We gotta do this, burn it up! Tear it up! Foolishness. I didn’t like Martin Luther King, oh God!

Nick: No?

Eddie: Whew! [*chuckles*] No, no, no! None of my crew backed Martin Luther King back then.

Nick: Why not?

Eddie: We'd turn on the tv and see people getting beat and whatnot, and he said, "Don't fight back," and so forth. We was more with Malcolm X, you know, "by any means necessary." "They hit you, hit back. They do this, do that." We was feelin' that. That's why we had some people saying, "Martin Luther King is working for them. He's getting our people beat. You see on tv, that girl? The cops beat her down with a billy club, and the woman..." and all that. And it was... sickening, you know. You see people on tv getting beat with billy clubs and all like that and they not fighting back, they just marching, holding each other's hand. It was sickening, and we thought that he was like leading our people to slaughter.
[...]

Nick: Do you still feel more aligned with Malcolm X?

Eddie: Well I always did because, see... A lot of people don't know this but there were two revolutions going on back then: you had your Black Revolution and your Negro Revolution. Martin Luther King was with the Negro Revolution. Malcolm X was with the Black Revolution. The difference? One was fighting for civil rights – that was Martin Luther King, and one was fighting for human rights – that was Malcolm X.

See, when you talk about *civil rights* you talking about a *domestic* problem within a certain country. Nobody else could get involved in a country's domestic problems, no outside countries, the UN or nothing like that. But a *human rights* problem, you got the world court, the UN, so forth and so on, could get into a human rights problem... and that's what we felt as though we was having, a human rights problem. We was being denied our human rights here in America. And that's what Malcolm would fight for. That's why he talked to different African nations and so on, cause we was trying to get a seat at the UN so we could bring our case before the world. We didn't want to keep it domestic. And that was the difference. As long as we keep it domestic, I'm depending on the people that's beating on me to give me justice. That's what it was like to us. [...] And I guess you could relate the same to this right here. Healthcare's one of those things.

Despite the Nation of Islam's separatist stance and their rejection of U.S. nationalism, many of their activities fed into litigation for the recognition of prisoners' rights through their notion of group unity and victimhood of racial oppression (Berkman 1979; Jacobs 1978; Pallas and Barber 1972). This unity persisted even after the group began to fracture in the mid 1960s, and manifested in appeals to the state once the group

followed the lead of Malcolm X and veered away from separatism.³² Indeed, one of the first landmark cases of the prisoners' rights movement, *Cooper v. Pate*, was filed to allow Muslim inmates access to the Qur'an (Jacobs 1980). Eddie's account details the results of these mixed politics, recognizing that the racial line dividing blacks and whites resulted in the extreme contradiction of "depending on the people that's beating on me to give me justice." Even though Eddie, still a practicing Muslim, now saw himself as "a human person" who relied more on "mutual respect and cooperation" than primarily race-driven politics, he recognized that this contradiction has persisted through the racial subjugation of mass incarceration in the U.S. and the reliance on the state to provide health services and health justice. In fact, following an interview where he delved most deeply into his racial politics from the civil rights era to mass incarceration, he asked me plainly, "Have you read Ms. Alexander's book?"³³ Eddie's history of racial justice struggle highlights the need to break from domestic forms of nationalism that have always and continue to subjugate people of color – under which it is impossible to enter the social contract of rights and gain full citizenship – and to make appeals to forms of personhood and humanity that exist independent of the state, something I return to in Chapter 5.

Although the law is not the only – and may not even be the most effective – political strategy inmates have, the legal infrastructure established in the wake of *Estelle* and the ways it pervades everyday practice and the personal histories of folks like Eddie has engendered a situation where "class struggles seem to have metamorphosed into class actions" (Comaroff and Comaroff 2006:27). Healthcare is consistently the most litigated issue among inmates across penal institutions and at levels of claimants from individuals to class action (see for example Schlanger 2003a). *Estelle* and subsequent litigation has brought the health rights of inmates squarely under the purview of courts and infused the delivery of healthcare with legal meaning, a process that anthropologists of Latin America have called the "judicialization of health" to conceptualize the right-to-health legislation that has accompanied democratic transitions in those countries (Biehl 2013; Biehl et al. 2012; Littlejohns et al. 2012; see also Couso et al. 2010). This follows from a larger trend that the Comaroffs identify in postcolonial settings of the "judicialization of politics" (2006) where sociopolitical issues of race, class, religion, sexual orientation, etc.

are displaced onto courts for resolution, and legal discourse and authority inform diverse sets of practices, reshaping the possibilities for justice and citizenship. As Biehl and Petryna mention of claim of pharmaceutical litigation in Brazil, the “judicialization of the right to health generates intensely complex sociomedical realities” (2013:328).

Inmates are forced to become conversant in the language of the law and adopt a certain legal subjectivity simply by virtue of going through the conviction process and becoming interpellated into the bureaucratic order of prison life like acquainting themselves with the rules contained in the prison handbook. Most of the men I spoke to, including Eddie, spent a lot of time researching and working on their legal cases, and for many of them being a “jailhouse lawyer” or “legal eagle” became a marker of political action, realized somewhat ironically as taking a radical stance in response to the conditions of punishment and disempowerment they faced in prison. Such a position also held social capital among inmates, who would look to each other for support and assistance in lawsuits they were filing or in navigating their original conviction case, even if litigation served to reinforce a reliance on the “rule of law” and supported the illusion of justice in a biased system (see also Abu-Jamal 2009).

The judicialization of inmate health politics became especially evident in my conversations with Darrin. A thoughtful speaker and critical thinker, Darrin was a 50 year-old black man whom I met while he was in the infirmary preparing to be sent out for a colonoscopy. He was very thin and always kept his head shaved and salved with cocoa butter he had purchased from the prison’s commissary. Darrin was especially concerned about his nutrition and digestion, which I revisit briefly in Chapter 3, which resulted in frequent requests to medical providers for diagnostic tests and imaging, which were also frequently denied. Darrin was one of a group of three inmates who sued the state for access to his medical records back in 2010. He took this action so that he could send his records out to his family for independent review when he felt like he had health issues that were going undiagnosed and thought that treatment was being withheld for his asthma. In the context of discussing the A Block protest, he described how reading anticolonial literature in prison became a source of political inspiration and motivated his experience of political awakening, which manifested in legal action. He remembered that

a critical moment in this process was reading a passage in Frantz Fanon's *Wretched of the Earth*, a Marxist psychoanalytical text widely read among black (prison) radicals about the dangerous effects of nationalism and colonialism in Algeria. Although some regard as being a call to exercise violence to effect revolution against oppressive regimes,³⁴ Darrin saw its message in understanding state processes through involvement with them:

[Fanon] was saying that people don't know their government until they are actually in the courtroom. That's when you find out who your government is. And that was like...that was a profound statement. I was like, "I can agree with that line, because you really don't know." People are conditioned to just believe because a person of position says a thing, but until you actually see it or hear it, engaged in it, and you're like, "Oh this is not how this is supposed to go!"

Claiming a position unaffiliated with religion or activism beyond critical thought, Darrin read Fanon's discussion of the mechanisms through which colonialism disguises power in the law as justification to decipher those mechanisms and work within them, somewhat counter to Fanon's claim that decolonization "implies the urgent need to thoroughly challenge the colonial situation" (2004). Darrin elaborated that the disguises of power serve as a basis for asking critical questions to the state. He suggested that such questions might have motivated the situation on A Block as he began to speak from the perspective of a hypothetical, disillusioned inmate:

It's like, "I need you to give me some clarity because I believed you were representing my interests, but you're not. And I feel like I'm getting the shaft, so I need you to give me some clarity on some things." I think that's what was the impetus for the A Block situation. You can only go so far before you say I need you to hear me because you're not hearing me, and I have to find out what is the most logical, strategic, safest way I can get you to hear me without you misinterpreting what I'm trying to say.

For Darrin, the most logical, strategic, safest way for him to be heard was through the legal system, hoping to get a judge that would recognize that he should have access to his records, in a long and costly legal process. His tactical reading of Fanon epitomizes the general trend outlined in the judicialization of the right to healthcare for inmates.

Although critiques of rights and state power were still clearly prevalent among inmates, they tended to be transformed into a method of political praxis that worked within and alongside the law rather than against it.

Henry, a middle-aged, white technician at Graterford who had the longest tenure of anyone on the healthcare staff, always freely vocalized his opinions, meandering through the halls of the medical unit as he went on with his work. Once he described his reactions to the emergence of lawsuits as a form of political action in the past few decades. He laments the earlier days of less savvy inmates and situates the prevalence of lawsuits in the context of racial struggles for civil rights, pitted against the cost of actually providing rights incurred by Wexford, the company that provided healthcare services at that time:

You've got a lot of civil rights cases nowadays. There's a lot of angry black men here who have gotten more sophisticated lately and they start to write lots of stuff down to try to prove something so they can start a lawsuit. You've got more people here. Years ago, with 2000 inmates here, not a lot of them were too bright. Like, I say a lot of them were just street thugs. We had a few smart guys called jailhouse lawyers. Now you've got more people in here, and you've got the internet available outside here where family people can send things in, and I think they've gotten a little smarter. And of course a company like Wexford, the idea is not to spend money. You don't make money by spending it. You make it by not spending it. So naturally they're not going to want to order anything that's going to cost money outside of here, no extensive tests, no... Now if the inmate gets a hold of that and finds out you're holding out... [*shakes his head*] then you're setting yourself up for litigation.

Not only do Henry's comments evince a form of contempt for inmates and a point of view that the rise of lawsuits as a more legible form of political action indicated a concurrent rise in intelligence, but it also starts to outline the practice of healthcare rights in the clinic, which merges with the company's incentive to save money while also evading legal culpability.

Rights in the Clinic

The judicialization of inmate health has paved a two way street between the courtroom and the prison medical clinic. Healthcare access has turned into a legal matter

that that must be fought over in formal proceedings that are invested with other political struggles and, as I have shown, ideological commitments to punishment. At the same time, healthcare litigation has reflected back to the clinic, creating a dense entanglement between the law (and its inscriptions of punishment and deservingness) and the practice of medicine. Given this dialectic between courts and prisons, the clinic is where Eighth Amendment constructions of “deliberate indifference” and “serious medical need” become invested with practical meaning. These vague legal standards take on specificity in their implementation and have important implications for the delivery of healthcare, how inmates seek and define care, and if and how inmates make claims to health justice in the legal arena.

Combined with the economic incentives to keep costs low and delay care, the legal constructions set forth in *Estelle* help define an economically and legally acceptable point of medical intervention upon suffering. In this literal and figurative economy of suffering, healthcare providers take on new orientations to care that save money and evade legal culpability. The Eighth Amendment right to healthcare in practice therefore dictates how and when suffering can become apprehensible to the medical staff and the legal system, as was seen with Mr. Leonard at the beginning of this chapter, when his suffering only became visible when it posed an imminent threat to his life.

Since the 1980s healthcare for the Pennsylvania Department of Corrections has been contracted out to private, for-profit companies. The drivers of privatization were related to the exponentially increasing prison population and both the strain on resources and the litigation that resulted, which created court mandates to help manage costs and increase staff rather than decrease the prison population. As private enterprises, the companies that provided healthcare services to the prisons won contracts with the state based on their proposed budget for the contract term and made money by implementing cost-saving mechanisms to try to spend less than their proposed budget. Consequently these companies’ budgets needed to propose a high burden of illness requiring costly treatment, and could profit either because inmates did not experience the predicted level of illness burden or illnesses remained undiagnosed, undertreated, or untreated. Other literature on managed care contexts has demonstrated that preventative care, which would

eventually lower the illness burden, is less cost effective initially and therefore not prioritized over the rationing of care and shifting the cost of healthcare onto other payers (see especially Rylko-Bauer and Farmer 2002; Sullivan 2000). While I describe these logics more in Chapter 2, I bring them up here in order to point out how this rationing took on an explicitly legal valence. Because the practical derivation of profit for these companies relied less on preventative (or in the case of Hepatitis C, curative) care, it instead relied on the deferral and rationing of medical interventions, on the production of suffering to the point of what was considered legally “serious.”

Reflecting on the high financial cost associated with the legal obligations the institution has over the lives of inmates, Henry conveyed how the interplay of cost and legal obligation collide at the point of serious intervention, where costs could sometimes be the greatest. Discussing the changes he had noticed in healthcare over the years, Henry mentioned the different ways outside providers (in this case emergency medical technicians) and on-site providers make management decisions based on a mixture of their legal medical obligations and financial considerations:

We never had a helicopter come in here to transport guys out. You just called the ambulance. Now a helicopter shows up with a \$30,000 bill! And the EMTs unfortunately make that call, not the people here. If you call a medical director and say, “I got a guy in here with so and so,” He’d say, “Well just put him in an ambulance.” When the EMTs get here, if the guy has lost consciousness, if he’s got a failing heart rate, they call a helicopter. They don’t care what the bill will be. It’s not their problem. It’s their job to get the guy to the hospital *alive*, so... that’s where we get stuck with the big bill.

Henry continued, commenting on how these interventions could be costly, but unavoidable given the exceptionality of the United States compared to “third world countries” in giving the right to medical treatment to its inmates:

We’ve had guys come in with heart attacks, we’ve had guys shipped outta here who’ve had pacemakers... big bills! Big, big bills! But again, it goes back to “if you lock ‘em up, you basically have to take care of ‘em.” It’s not a third world country.

Earlier in our conversation, Henry mentioned that the right to healthcare that goes along with confinement to state custody had made inmates entitled and demanding of the highest quality care, a perception he shared with most of the healthcare providers. In a moment that combined this perception of entitlement with the legal contours of care delivery through the definitions of “deliberate indifference” and “serious medical need,” Dr. Keller was sitting in the security bubble of the prison infirmary when he started to regale one of the nurses and me with a story from his diabetes clinic the day prior:

This guy with chronic pain snuck his way into diabetic clinic yesterday. I don't know how he did that! He wouldn't shut up, so I just let him talk. And I'm doing a straight leg raises, I have him touch his toes, and check him for scoliosis, and he's not even in any pain. He's saying he needs an MRI and he needs this, and I tell him he doesn't. Then he starts crying, “Oh! Deliberate indifference to my medical needs!” You're right, I *am* being deliberately indifferent... but you don't have any medical needs!

These encounters demonstrate how the legal constructs of medical need and deliberate indifference enter into the everyday worlds of medical providers, helping to create a language to describe what belongs in and out of the clinic and serving as an object onto which they can project ideas about cost and deservingness in the practice of prison healthcare. Combined through notions of demanding and costly inmates, Henry and Dr. Keller's comments highlight critical pieces of the intersection of medical practice and legal discourse in the prison. Henry's comments demonstrate how legal obligations to treat come with price tags. The two then become institutionally negotiated in ways that still reasonably sustain the obligation to “keep inmates alive.” Dr. Keller's story gives an example of those institutional mediations in the form of defining medical need.³⁵ Crucially, if one does not define the medical need, one can be as indifferent as one wants. It therefore becomes apparent that the right to see a doctor and be afforded a professional opinion granted in *Estelle* mean little if the structuring of the clinic, the documentation of medical complaints, the cost of treatment, and systematic evaluation of those complaints are only loosely guaranteed.

Diabetes, the condition Dr. Keller's clinic was organized around, is legally understood as a serious medical condition,³⁶ hence the reason why an entire clinic is constructed to routinize medical visits for it, and why a complaint like pain is displaced and devalued in such a configuration. "Chronic clinic" sessions at Graterford were all organized around conditions that were legally considered serious,³⁷ and prisons were obliged to demonstrate reasonable tracking and follow-up.³⁸ As part of the prison's obligation to provide care for serious medical conditions under the Constitution, inmates were also not charged co-pays for these visits. The co-pay policy was implemented as a way to cut down on "unnecessary" use of medical services, forcing inmates to make the decision of whether paying \$5 (approximately 30 times their average hourly earning potential, yet an insignificant portion of the overall medical budget) for a medical visit was worth it to them, potentially impinging on the diagnosis of the chronic conditions that are exempt from the co-pay. The legal construction of seriousness therefore manifested in the entire organization of the clinic including if and how inmates were charged for services, having health complaints take the form of specific channels for specific disease processes. This resulted in the policing of symptoms and complaints in these clinics, limiting physical exams and discussions only to the serious medical condition.

Having "serious medical need" function as the hermeneutic for medical claims not only affected the structure of the clinic, but also reified serious medical need as the primary point of intervention on inmates' health. Because these conditions are defined as those that, if left untreated, may result in death, death became the focus of obligation and intervention – that which holds the most potential to come under legal scrutiny – as demonstrated in Mr. Leonard's case. It remains difficult to disentangle the motives of healthcare providers in their desire to prevent the death of inmates. Though such acts were also informed by genuine compassion and providers' oaths as healthcare professionals, providers also discussed feeling an increased pressure to avoid lawsuits than that typically experienced by healthcare providers practicing on the outside and openly recognized that the care they provided might be informed more by this legal responsibility than the pursuit of health for inmates on its own merit. The example that

Claire gave of the moving target of Hepatitis C care in the face of an ongoing class action suit presented in the introduction is a clear example where treatment was provided more to demonstrate action on the part of the DOC and Correct Care Solutions in the face of the threat of death than what might be medically indicated for the patient. “Teaching cases” that were occasionally worked through in staff meetings to determine the appropriate diagnosis and management of a patient also contained these rationales. Initially introduced as “training” sessions, these cases taught much more than medical management. Cases were similar to morbidity and mortality conferences³⁹ in that they were based on actual patients incarcerated in a Pennsylvania prison where there was mismanagement and a subsequent lawsuit. Thus, the logic of remaining impervious to legal culpability after an inmate’s death was even reproduced pedagogically.

I heard numerous accounts from correctional officers saying they “went through the motions” of performing CPR on inmates who had been dead for hours just to show they had done “due diligence” and “it would show on the report that they did it.” Similarly, when Mr. Baldwin, an inmate with hepatocellular carcinoma resulting from chronic Hepatitis C infection, died one morning in the prison’s infirmary, the supervising physician jokingly commented, “Mr. Baldwin hadn’t gotten around to signing a DNR yet, so I vigorously coded him... for about 4 or 5 seconds.” It was true that Mr. Baldwin was receptive to signing a DNR in a conversation he had with Dr. Keller a week prior to his death but had not yet signed one. In this sense the physician’s response is understandable; he wanted to respect the fact that Mr. Baldwin would not have wanted extreme measures, but he still needed to act based on what was (or was not) documented. However, his comment also reveals how this obligation and concern of liability is always at the front of providers’ minds, not to mention the structural values Mr. Baldwin placed on his life that may have influenced his decision to avoid medical intervention at such a late stage of illness. The physician then went on to say, “Hepatocellular carcinoma didn’t kill him! Technically it was metabolic failure. We wrote, ‘cardiac arrest’ in the chart, though... just to be safe.” This way, though his Hepatitis infection was documented, the direct link to his death was erased, evading questions that could be asked by lawyers down the line about early detection, treatment, and prevention. Coincidentally this was not the first time

the physician, who returned from retirement to work in the prison part time, had “fudged” a death certificate. A month or so prior he confessed that during his residency he altered the death certificate of a “drunk with end stage cirrhosis” who was given a compound used to stop bleeding that was reagent grade (i.e. used in a laboratory) and not pharmaceutical grade and subsequently died. “Here’s a guy with bad liver disease who probably would have died anyway,” he said, “and the hospital has a pretty good reputation, so I wrote liver disease on the death certificate, but I went up to the chief later and said, ‘We’ve got a problem.’”

Lance, who developed strong personal relationships with his patients and typically worked hard to advocate for them, expressed sadness at Mr. Baldwin’s death, to which the physician responded snidely, “I’m sure the ex-Mr. Baldwin appreciates your sentiment.” Lance then asked, “Was he a lifer?” and immediately preempted any response with, “Well, I guess he is now...” Lance also expressed his ideas about the rendering of “life” as an object of legal and medical attention in another moment, where he claimed that healthcare providers should not be legally susceptible to scrutiny over the death of an inmate whose life was conscribed by state custody: “I think if the state has determined they are going to serve life, they should serve their natural life. For me that means a natural life... you know, one without medical intervention. Let nature take its course.” Taken together, Lance’s seemingly contradictory sentiments of concern and withdrawal reveal that though standard rationales of care operate in the prison, the concern centers on a legal and financial obligation to provide a form of care with death, rather than health, as its object. Thus concern with death becomes the practical limit at which suffering in the prison becomes recognizable and is acted upon.

Experiments with Legal Legitimacy

The medico-legal constructions that have been detailed thus far created distinct and at times counter-intuitive realities for inmates who struggled to navigate health and legal services while incarcerated. Many inmates like Darrin expressed the anxiety that the medical staff knew that they had health issues that were not being addressed because they did not meet the standard of seriousness as interpreted by the providers, or if they were addressed, could only take a limited form of expression in the chronic clinics or were

subject to a copay they could not afford. Similarly, pursuing legal action against healthcare services was seen as increasingly difficult in light of judicial restraint, standards for indifference, and the increasing role of the Prison Litigation Reform Act of 1996, which set limits on lawsuits and required that inmates demonstrate appreciable physical harm and exhaust institutional grievance processes (see Schlanger 2003b; Schlanger and Shay 2008; Vaughn and Carroll 1998). As mentioned before, many inmates also readily recognized the biases in the American legal system that influenced their conviction, and were therefore apprehensive about seeking relief through the very same system. As a result, the boundaries of the clinic were constantly policed around a political, economic, and legally recognizable form of suffering, and inmates were made to inhabit the contradictory nature of their rights and the sense of insecurity that went along with them – to embody the status of “wards of the state.”

Roger, a 46-year-old black man who was serving two life sentences on felony murder, gained paralegal training after his incarceration. After meeting him at one of his sick call visits, Roger sat in front of me, his face pockmarked with patchy hair and scars along the multiple swollen lymph nodes on his neck, and described how he was diagnosed with an incurable form of lymphoma in 2009, after seven years of uncertainty and deferral at Graterford. An abnormal lab result was conveyed to him back in 2002 during a private meeting where he was called up to speak to a physician assistant. After discussing this result with his niece, who was a nurse, he asked the medical staff about the possibility of cancer. The response he got at the time was that there was no need to worry. “We aren’t using the ‘c-word,’” he was told. It was seven years later that his lymphoma was finally diagnosed, after his condition got much worse and after he had undergone multiple procedures in the prison to cut open his enlarged lymph nodes because the medical staff treated them as abscesses. By the time his lymphoma was diagnosed, Roger was transferred to another prison in a different part of the state, just after his grandmother had died of cancer, to undergo specialist oncology treatment. His impression at the time was that he was being transferred as a cover up, so he would die inconspicuously at a different facility.

Roger's rationale for why his cancer treatment was delayed and went undiagnosed was so that the state could avoid having to pay the cost of his expensive chemotherapy. When describing why he thought they would have withheld this information and not treated him earlier, Roger provided a more frank account of what I understand to be underlying Dr. Keller's comment above about defining medical need. Roger said to me, "The law is clear. If you don't diagnose it, you don't have to treat it. Once you make a diagnosis, you have to treat it, and that costs money, so they know that people have stuff, and they not telling people that they have that stuff until they on they death bed, or if they return to the community." Regardless of whether the financial burden was at the forefront of the minds of the healthcare providers back in 2002, or if they knew he had cancer but avoided making a diagnosis (in other words, recalling the intent-based standard of deliberate indifference – regardless of their intent – which is of course not ascertainable in their documentation), the diagnosis was not made or charted. It was clear at the very least that they did not find his symptoms serious enough to warrant a more rigorous workup or treatment beyond isolated management of misdiagnosed staph infections.

Roger's story and the stories of many inmates like him demonstrate how inmates feel the legal standard of deliberate indifference is skirted by incomplete or surreptitious documentation, and their medical needs are left to progress until they reach a level of "seriousness" that warrants the mobilization of economic resources and the inescapable legal obligation to treat. This is one reason why the man with chronic pain in Dr. Keller's story may have "snuck into" the diabetes clinic to receive care, and why many inmates attempted to use their visits in chronic clinics to bring up additional medical concerns but were met with resistance or even hostility on the part of the providers. Miriam Ticktin, (2011) in writing about regimes of humanitarian care among the *sans-papiers* in France, describes the production of a universal, morally legitimate suffering body. Ticktin demonstrates ethnographically how such moral legitimacy becomes recognizable and acted upon alongside the simultaneous production and criminalization of its opposite, illegitimate suffering. In a similar vein, we can talk about the legally legitimate suffering body produced in the prison context. The suffering inmate becomes recognizable in both his vulnerability and political specificity as a ward of the state while also being able to

make claims based on the legal formulation of the universality of suffering. Appeals to “evolving standards of decency”⁴⁰ and the “minimal civilized measure of life's necessities,”⁴¹ that evoke liberal humanism were used to elaborate the notion of cruel and unusual punishment in Eighth Amendment cases regarding prisoners’ healthcare. Legally legitimate suffering’s opposite, then, is unrecognized and illegitimate suffering. Such suffering remains hidden from the state and the public, and is relied upon to derive profit and escape legal culpability. If and when healthcare providers apprehended and acted upon illegitimate suffering, it was punished through the security and disciplinary functions of the prison.

In such a configuration, care and the possibilities for a form of citizenship that recognized the legal personhood of inmates at Graterford were delineated by consignment to a structured form of both state ownership and state belonging. In order to seek care and a role in the judicial process that sets the standards for that care, an inmate was made to assume the precarious position of being the biological and financial property of the state and also to internalize and embody the logics that accompanied the judicialization of health. Inmates therefore came to understand bodily pain and injury in a complex value scheme involving legal, interpersonal, bodily, and monetary worth. Reformulating Derrida and Foucault’s conceptions of the possibilities of freedom for the subject of power and governance, subaltern scholar Gayatri Spivak claims freedom involves the “persistent critique of what one cannot not want” (1993:42). Her double negative precisely articulates the deep ambivalence of being a ward of the state within a framework for prisoners’ rights. Inmates could not help but desire care and rights despite the paradox of literally belonging to state in order to gain social recognition from it. Furthermore, such recognition could only take place through the recognition of a certain form of legally legitimate suffering. The desire for care and rights were therefore sought in the law and the clinic, and those sites became spaces where citizenship was simultaneously made and unmade.

In this sense healthcare occupies somewhat unique territory. Healthcare services offer a form of state recognition and investment, albeit one that is tempered with incarceration and the forces that produce the “civic death” and “social death” experienced

by inmates.⁴² Inmates thus become both citizens of the state with certain rights as well as the property of the state, stripped of citizenship. “Ward of the state” expresses this dichotomous feeling, the condition of being both citizen and subject (Mamdani 1996). Unfortunately, this ontological duality is not new to black existence in America, though it takes unique form in prison healthcare. In essence, being a ward of the state is a continuation of W.E.B. DuBois’ “double consciousness,” a multi-faceted conception of the self and the struggle to reconcile those conceptions. In DuBois’ formulation, this double consciousness was an internalized reflection of black identity (that can never be fully American) and American identity (that is always undermined by racial othering): “two souls, two thoughts, two unreconciled strivings; two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder” (1989:3).

In situations where inmates feared their medical conditions remained outside what might be recognized legally as legitimate or “serious,” the delays in treatment and this limited scope of recognized suffering also took on specific racial significance, becoming the political site for the collective historical memory of experimentation. Inmates invoked the Tuskegee syphilis experiments where black men were given sham treatments in order to study the natural progression of the disease and the Holmesburg Prison dermatological experiments that took place in the Philadelphia jails in the 1950s, 60s, and 70s (see Hornblum 1998) in my conversations with them. Eddie was even incarcerated at Holmesburg while the experiments were still going on, contributing to a profound lack of trust and inherent suspicion in medical services, especially the profit derived from them.

Inmates used these instances where black men served as available test subjects as a way to convey the vulnerability of being at state property. They linked experimentation with experience of living with the heightened suspicion of manufactured documentation that or diagnostic withholding that Darrin and Roger spoke of and the derivation of profit from prolonged suffering. The reconfiguring or delaying of medical intervention during incarceration, facilitated by legal doctrines, therefore took on specific racial resonance and evoked the history of racial public health experiments disguised as interventions. In this way, the collective historical memory of suffering under Tuskegee and Holmesburg became embodied in the suffering inmates endured that remained outside of the view of

medical and legal services.⁴³ Inmates therefore labeled this kind of suffering appropriately as “experimentation,” but an experiment with legal and economic – rather than overtly scientific – purposes. Darrin commented:

I think that money’s always the primary objective because if you keep the cost down, you’ll get to stay with the state longer. So a lot of times guys’ medical conditions are actually forced to get worse, and ... dare I say experimental... but sometimes, yeah, because well [the providers and the company] wanna see, well, how far things can go before we treat it.

Eddie painted a clear picture of what it is like for inmates to become wards of the state in this sense of the vulnerability to state profit from suffering. He had just returned to the infirmary one afternoon, coming from a meeting with a group that collaborated with the Philadelphia Mural Arts Program. The program was working on a restorative justice project where they planned murals in consultation with inmates to portray an issue of importance to them, and the murals were painted throughout Philadelphia in communities most affected by incarceration. When Eddie returned from his meeting, he told me that the new mural’s theme was going to be “fatherhood.” “They want to do something that shows the impact that incarceration has on kids who are without they fathers,” he said. “Now, that’s all good, but that’s not exactly what I would choose. We do something like that every time. That’s not the message I would like to send. I would like to do something that shows what it’s like to be an inmate.” I asked Eddie what such an image would look like and what message it would send:

If I were to paint a picture of what it’s like to be an inmate, I’d put a guy posed like Atlas, you know with the world on his shoulders. Except instead of the world it’d be a big plate. And you got everyone eatin’ off his plate, right. You got the police man, the judge, the corporations, the doctors, the nurses... everybody eatin’ off this man’s plate he’s holding up. And then you got the convict’s family at his feet with the shackles, and they hungry. They ain’t got nothin’ to eat, but everybody else capitalizin’.

Eddie’s description conveys the experience of being the financial and biological property of the state, which was reiterated by nearly every inmate that I spoke to. Some

men would even ask me directly if I knew if the state continued to own them in death. Troy, whom I introduce in Chapter 3, said, “I don’t think they even release your body. I think they bury you in the back. Until you max out [complete your sentence] I think you still state property. I think they bury you in the back of this jail.” The notion of state ownership, as with the other phenomena outlined here, has a deep racial significance in legal history. One of the very first cases of the prisoners’ rights movement was the 1963 Supreme Court case *Jones v. Cunningham*, in which it was decided that inmates in state custody have the ability to file writs of habeas corpus, contesting the legality of their confinement. As Alexander Weheliye describes, “habeas corpus, and the law in general, at least when it is not administering racial distinctions, tends to recognize the humanity of racialized subjects only in the restricted idiom of personhood-as-ownership” (2014:4). Therefore, the *Jones* decision and the subsequent decisions of the prisoners’ rights movement, including *Estelle*, helped define legal personhood as state ownership for inmates. Doing so extended a history of legal decisions that codified black personhood under the liberal and capitalist notion of property, including the famous 1857 Dred Scott case, where his writ of habeas corpus was denied because, as an escaped slave, he was not recognized as a legal citizen (see 78). Specifically referring to Eighth Amendment claims, Dayan argues, “In the repeated attempts to decipher the meaning of Eighth Amendment language, interpretation makes possible the denial of inmate claims while negating the humanity of the confined body. The legal demolition of personhood that began with slavery has been perfected in the logic of the courtroom” (2001:22). These legal-historical parallels point out how deeply embedded configurations of legal, moral, and racial personhood influence modern rights and the possibilities of political and racial subject-making.

When speaking specifically about his rights as an inmate, Roger made direct comparisons to the Animal Welfare Act, which set regulations regarding the ethical treatment of animals used for experimentation:

We live in a time period where the treatment and life of an animal is more important than the treatment and life of a person.... If I kick a dog I could be nailed to the cross! If I kick a person, nothin’ happen. I think it was Nixon,

President Nixon signed an act about using apes as test subjects, said that you gotta have this amount of space, you gotta have this exercise, they gotta be fed this, and stuff like this, and have this *care*.... For a ape – for an animal! But when you switch to the prisoner population, you don't have to have that!

His comment calls to mind what Marjorie Spiegel calls the “dreaded comparison” between animal and human slavery (1996), which is ultimately undergirded by the notion that humans have achieved full status under the law, and attention should be diverted to the emerging crisis of animal rights. Roger highlights the flaws in these assumptions and the ease with which we may draw uneasy comparisons between the struggle for inmates’ rights and the deservingness of non-human animals. He points out that inmates were never granted full legal status.

Although it is often cited that the disproportionate incarceration of African Americans represents a loss of the gains of the civil rights movement, especially through an anxious white response to those gains,⁴⁴ Eddie’s experiences during this time and the recognition that black people were never fully equal before the law (see for example Singh 2004; Muhammad 2010) lends a form of historical continuity to the condition of wardship experienced by inmates. Although gains were made in both the civil and prisoners’ rights movements, they were always already undergirded by racial othering and the legal recognition of black people as less-than-human, as a limit-case in Western constructions of liberal personhood (Arendt 1951; Weheliye 2014; Wynter 2003).

Finding the Value in Law

So far I have described the legal paradox of providing inmates with a Constitutional right to healthcare whereby the state is simultaneously responsible for harm and relied upon to protect inmates from harm. As legal and political philosopher Wendy Brown states of the value of paradoxical legal rights language, “Paradox is certainly not an impossible political condition, but it is a demanding and frequently unsatisfying one” (2002:430). In their attempts to seek forms of justice and citizenship in the law, many inmates recognized the systems of value and profit linked to suffering and attempted to leverage that value. Inmates articulated the decision to pursue lawsuits and to mobilize the suffering they had experienced at the hands of the state as a way to “seek

monetary value for the state's mistakes" – the only way to make a lawsuit "worth it." One thing that came out clearly in these descriptions was that inmates are often forced to seek a form of justice that was not based on systemic structural change or the imputation of criminal charges that might hold individuals or institutions accountable. Instead, they relied more on demonstrating vulnerability and the literal value of suffering during incarceration than on proving the criminal wrongdoing of institutions or the people who act within them.

Russell, a young, mixed-race inmate with epilepsy as a consequence of head trauma he had endured more than a decade prior, described this logic of the legal, interpersonal, and monetary value of suffering to me in the context of discussing his own medical issues. I had first met him when the medical staff sent him back to the block from the dispensary when he came in experiencing an aura that usually preceded his seizures. The provider overseeing the dispensary at that time told him, "We treat seizures. We don't treat aura," and had him sent back to the block. Russell had explained to the provider that despite being seizure free for the past eight months, he was experiencing his usual aura likely because of a recent change in his medication. The provider, however, claimed that there was nothing he could do unless Russell was actively seizing. In our interview, Russell described his response to the encounter and reiterated the staff's ability to define medical need based on economic rationing of pharmaceuticals:

I didn't expect [the medical staff] to exactly treat it, but you know... observe is probably a good idea instead of just telling me to walk back to my block. So, I dunno... I found that kind of odd. I can't think of anybody outside of jail that's a medical professional doing that. But I'm not surprised by that kind of thing anymore. Some people are good and some people aren't. Some people care and some people don't. And then there is policies that just, like, seem to be pointless. For instance, if somebody's been deemed in need of medication, and has been given the medication here for a while, and then all of a sudden the DOC decides that that drug is no longer on formulary, how does that change the person's medical need for it?

While we were discussing what he felt like he had to do to ensure that he got the proper medication and his lack of surprise at this kind of treatment, Russell described

how the institutional grievance process rarely worked, and what a disadvantaged position inmates are put in if they do decide to pursue a lawsuit:

Russell: That's the only step after [grievances]. [...] They have no other recourse except for a lawsuit. And then you have to say to yourself, "Well, is it worth it for me to bring suit over this?" Also, you have to ask yourself, "Am I going to win?" because chances are you're not, because you don't have enough proof of anything in particular actually happening. You know, you can save all your paperwork, but all that shows is that you filled out a piece of paper. Technically, you could fill out a grievance, pull off the back thing – that's your receipt showing that you filled it off – you keep that, and then you turn the rest in. Now technically, you could take the rest of it and not turn it in, and just hold the receipt and just say, "Look I filed it." So it's really not proof of any sort. You're not likely to win. It's probably gonna be not worth your time and aggravation. Nobody really is gonna want to represent ya, unless something really bad happens to ya. My friend lost his testicle to MRSA in Bucks County Jail because they literally were like, "Whatever. We don't know what it is. It's probably a hernia." But it wasn't, and he ended up having... it was really messed up. Obviously. Like I said, he lost his testicle.

He got paid *a lot of money*. I would probably trade a testicle for the amount of money that he got, but you know, unless something like that occurs, you're not likely to make out too great. And then if you're stuck here and you file suit against the medical department *and you're still here*? Well then what kind of care do you expect? All of a sudden sick call slips get lost, and files disappear, and your meds run out early, and you don't know what's going on. Because that "no retaliation" bullshit is literally bullshit, because if you file a grievance on one of these guards because he talked to you fucked up or something like that, you can bet that he might not do anything, but his boys are gonna.... It's... it's a corrupt system.

But, like I said, I understand this. If you know how to operate within the framework of what you understand then it's not that big a deal. Not everybody would agree with me. Some people... it's funny, because when I was young, I was such a fucking anti-everything, militant about anything. And I guess that the world has kind of beat me down, because I'm really not like that any more. I'm really more like, "See, I told ya. This is how it goes." But I guess that's just cuz of my experience. I haven't *given up*. I just... don't see the point in a lot of cases.

Nick: What are some examples of the experiences that have made you feel beat down?

Russell: I don't really know if I could point to any one in particular. [...] You know the whole saying, "You can't fight city hall"? Well if you take city hall and switch it to the jail administration or whatever, it's basically the same. If you're

an inmate, even when you win, you had to go through so much to win and put up with so much shit, that you still lost. They never lose, cuz even when you win, they still don't lose cuz it doesn't matter to them that you won. Do you understand what I'm sayin'?

Russell's comments evidenced a more pervasive sentiment of officers and other prison staff looking out for each other and the feeling of powerlessness and voicelessness that went along not only with not having one's rights as an inmate upheld, but even with winning a lawsuit against such a juggernaut institution. Individuals in these circumstances were seen as potential lawsuits that could only upset the overall operation of the prison a little bit, and only by disrupting the state's budget, which cognitively (and in many ways functionally, since the state's budget was always in flux and the Department of Corrections was always making different appropriations requests) did not exist as real money. We continued our conversation about Russell's feeling of acquiescence and insignificance:

Russell: I've seen it over and over. And it goes for medical, to security, to every part of the system... every part. You never really win, and even if you somehow get a little win, they didn't lose, and your win is close to inconsequential. So... I mean that's really all there is. And that's how I view it, and I think that I'm correct in my view. Maybe I'm pessimistic or cynical. I don't know.

Nick: And your friend who won his lawsuit... you mentioned that the "win" for him was the amount of money?

Russell: He got a lotta money... but he lost a testicle. And, like... nobody got fired. Nobody literally paid out of their pocket. The taxpayers paid that. Like... the money he got, nobody that screwed him, nobody that messed up and said, "Oh, you'll be fine," actually paid any money. So, like... they didn't really lose. They kept their jobs, and they didn't pay anything.

Nick: So what would be a win that would make it worthwhile for you?

Russell: Well that would... I would still... Look, if I was gonna get \$1.2 million I would go for it. It would be worth it, but my point is that's one of the only wins I've seen, and the price that he paid, i.e. the testicle, is still a lot. So like I said what you go through both physically, aggravation, all of that... maybe it's worth it. Another friend of mine lost this part of his finger [*gestures to tip of his finger, just below the fingernail*] in a sally port door and he got \$85,000 after. I think I

would do that, too. Do I really need this part of my finger? Probably not, especially not just from one. I have the rest of them! Fingernails are annoying anyway! You have to clip them... or bite them. But that hurt. It literally got chopped off by a door. That is not... I'd rather have you chop it off with a knife or a machete or something, because a door is dull, and that really had to hurt. I can't see purposefully subjecting myself to that even for that amount of money. At least not sober, so... but you know, it's not worth it because... you know what should make it worth it? When my friend lost his testicle and got the money besides the money is that they started being a lot more... it actually changed something for one of the very few times in my life that I've seen something changed. They started taking things more seriously. Now, it got annoying that any time you got an ingrown hair or something got a little big they would throw you on medical isolation. That's horrible, but at least they were paying attention and taking peoples' medical concerns seriously when it came to skin infections.

In elaborating the calculus involved in making a decision to sue, Russell recites his rationale for linking the value of bodily suffering with monetary payout, the most feasible kind of justice that one can expect as a result of a lawsuit. Despite his objection that individual and institutional accountability are missing from cases he had witnessed, the possibility of accountability and changing prison medical policy appeared only as an ancillary added benefit for what kinds of successes would make a lawsuit worthwhile. Thus, the feature of institutional change is neither readily obtainable nor built into the legal infrastructure for inmates seeking relief. Instead, one must hope for a level of financial payout that makes suffering "worth it."

As evidenced by this experience of suffering, the vague legal standards that define inmate suffering in relation to the legal obligation of care are incomplete at best. Inmates therefore felt at a disadvantage to be able to make substantive legal claims because of these justifications around the deliberateness of negligence and the seriousness of their needs and were left to inhabit a form of suffering that felt unrecognizable to the systems that were supposed to be in place to recognize it. Suffering circulated in these formulations of legal legitimacy and monetary value, where ideas about race, criminality, and deservingness became operationalized in an economy that was driven by the cost of care.

Roger, whose explorations of legal remedy and health justice I return to in Chapter 5, also opted to pursue an option that sought monetary compensation. He

invoked the obligation in *Estelle* that Henry also mentioned above that the state has to care for him and treat his lymphoma because he was incarcerated, explicitly drawing out the different kinds of value that are placed on life during sentencing and during imprisonment: “The thing is, when you gave me life, you said you was gonna take care of me for the rest of my life. Any time you wanna change the terms of that, we can change the sentence! If you don’t wanna take care of me no more, change the sentence!” Roger knew that his legal options to hold the state accountable were limited. Pressing criminal charges seemed impossible even though he felt like the staff was acting criminally and that these charges would be appropriate. Roger not only felt like there was negligence in delaying the diagnosis and treatment of his lymphoma, but that his incarceration had directly caused his cancer by virtue of exposing him to carcinogens. During our conversations he repeated phrases like, “They gave me cancer,” “They took my life,” and even “They’re committing murder,” pointing explicitly to the statute for first-degree murder in Pennsylvania, in which “premeditation” bears a strikingly similar degree of intent as the “deliberate indifference” clause from the Eighth Amendment litigation. Due to the significant burden of proof placed on him to substantiate this claim and the notion that healthcare providers had acted with malicious intent, however, he felt like this option seemed the most unlikely.

The economy of inmate health is therefore also influenced by the legal obligation to treat and the value suffering has within legal constructions of care and harm. Serious medical need and deliberate indifference circulate in value schemes that dictate the types of legal and medical recognition inmates are afforded, provider’s decisions about care, and the very structure of care delivery through the establishment of clinics specifically for “serious” chronic conditions. Thus, the formation and circulation of suffering in the prison context includes economic, political, and moral determinations that are shaped by the prevailing legal context and the infrastructure that has been set forth for inmates to seek relief. This economy compels inmates to mobilize their suffering in order to gain legal recognition, often in the form of monetary compensation. In this way, a price is placed on justice that involves both the valuation and valorization of human suffering as well as the devaluation of suffering for those whose humanity is denied. Inmates are

therefore constrained by the limitations of the law to provide only certain types of justice that come at such a substantial price.⁴⁵

¹ Inmates who were removed from their cells against their will, a procedure typically called a “cell extraction,” or who were being transported after a violent altercation were recorded on video tape to document any use of excessive force on the inmate. Tapes were typically internally reviewed by the security department and held by the Department of Corrections for a set amount of time before being destroyed or archived.

² Meaning go on a trip outside the prison.

³ The healthcare vendors audited trips to outside hospitals (and the expenses incurred), making a trip resulting in no treatment (a so-called “bounce back”) a source of corporate scrutiny and, therefore, a source of anxiety for the providers.

⁴ There is, however, a scheme of rights dictated by the type of crime after incarceration. For example, those convicted of felonies can no longer vote, possess firearms, or apply for federal assistance after release from prison. During incarceration, however, there is no such distinction. Indeed, pretrial detainees face the same determination of their institutional rights that convicted inmates face by virtue of their incarceration. In *Bell v. Wolfish* the Supreme Court decided that while pretrial detainees had a right to be free from punishment for crimes they were not yet convicted of, deprivation of liberties compelled by institutional necessity were permissible: “[T]he presumption of innocence plays an important role in our criminal justice system. [...] But it has no application to a determination of the rights of a pretrial detainee during confinement before his trial has even begun” (*Bell v. Wolfish*, 441 US 520 [1979] at 533).

⁵ Although there is a general consensus that prison conditions improved as a result of increased litigation during this time period, states demonstrated variability in their responses to increased litigation (Chase 2015), and this history tends to overshadow other forms of political protest and activism against racial oppression that was both taken up by prisoners and also allowed imprisonment to gain visibility as a social issue disproportionately affecting people of color (see also, e.g. Berger 2014; Cummins 1994; Tibbs 2012; Pallas and Barber 1972). Likewise, though prison conditions may have improved, it is widely recognized that the outcomes of the prisoners’ rights movement and increased litigation were not all beneficial. In fact, incarceration rates increased after this period as a result of conservative backlash against increased rights afforded to prisoners (Beckett and Sasson 2004), court orders that made prisons easier to build and manage (Feeley and Rubin 1992; Schoenfeld 2010), and the racial politics that contributed to the rising influence of victims’ groups (Gottschalk 2006). Litigation may have also led to stricter security, increased regulations and technical punitive measures, as well as more austere bureaucratic management of prisons even as physical violence decreased and facilities modernized (see Crouch and Marquart 1989; Jacobs 1978, 1980:457-463).

⁶ *Wolff v. McDonnell*, 418 US 539 [1974] at 555-556.

⁷ As a matter of distinction, other groups that have a legislative guarantee to access healthcare services in the United States under acts of Congress such as indigenous groups, veterans, the elderly, and children in foster care have the provisions of that guarantee clearly spelled out in federal legislation. Courts, therefore, have less to determine, especially in regards to citizens’ claims. Courts can find some aspects of the federal healthcare legislation unconstitutional, as has been attempted with the Affordable Care Act, but there is no direct line to the Constitution to supporting a healthcare claim as there is for inmates. As a result, despite the support afforded by the Constitution, much of inmate healthcare policy is defined under the obligation of care

emanating from the judicial elaboration on the sixteen words contained in the Eighth Amendment.

⁸ This description fits well with Hansen and Stepputat's definition of sovereignty as "a tentative and always emergent form of authority grounded in violence that is performed and designed to generate loyalty, fear, and legitimacy from the neighborhood to the summit of the state" (2006:16.3).

⁹ See also Browdy (1961) for an analysis of the limitations of the Eighth Amendment in contrast to claims based on the Civil Rights Act or habeas corpus before it became directly tied to inmate healthcare in *Estelle*, viz., the Eighth Amendment's reliance on a standard of harm so egregious as to shock the public conscious and the judiciary's desire to stay out of the administrative affairs that dictate prison conditions.

¹⁰ *Gutierrez v. Peters*, 111 F. 3d 1364 [1997] at 1373.

¹¹ *Nance v. Kelly*, 912 F. 2nd 605 [1990] at 607.

¹² In *Helling v. McKinney*, it was determined that exposing an inmate to second-hand smoke, which carries known health risks, violated the deliberate indifference clause in the determination of cruel and unusual punishment. In *Erickson v. Pardus*, the Court ruled that an inmate's claim for the risk posed to him in interrupting his treatment for Hepatitis C could hold as a potential violation of deliberate indifference. These rulings, however, stand in stark contrast to the majority of Eighth Amendment claims that make it to Supreme Court review, which deal mostly with harm inflicted by correctional officers or general prison conditions. Even in *Farmer v. Brennan*, where a similar question was at issue regarding the deliberate knowledge of harm posed by housing an transgender inmate within the general population, the Court found that placing the inmate in the general population could only constitute cruel and unusual punishment if it could be proven that the prison officials knew the precise risks of placing her there beforehand.

Lest *Helling* and *Erickson* be understood as a comprehensive expansion of inmate claims to health rights to universally include risk of harm, Justice Thomas wrote dissents calling for limiting judicial oversight in these matters. He writes in his *Erickson* dissent, citing his prior dissent in *Helling*:

I have repeatedly stated that the Eighth Amendment's prohibition on cruel and unusual punishment historically concerned only injuries relating to a criminal sentence [meaning the punishment involved in the sentence itself, in distinction to prison conditions and prison healthcare].... But even applying the Court's flawed Eighth Amendment jurisprudence, "I would draw the line at actual, serious injuries and reject the claim that exposure to the *risk* of injury can violate the Eighth Amendment (*Helling v. McKinney*, 509 US 25 [1993] at 42)" (*Erickson v. Pardus*, 127 S. Ct. 2197 [2007] at 2200-2201 emphasis his).

¹³ In the Court's words, "From the outset, thus, we specified that the Eighth Amendment does not apply to every deprivation, or even every unnecessary deprivation, suffered by a prisoner, but *only* that narrow class of deprivations involving 'serious' injury inflicted by prison officials acting with a culpable state of mind" (*Hudson v. McMillian*, 503 US 1 [1992] at 20), and "'mere negligence' does not constitute deliberate indifference under *Estelle*" (*Farmer v. Brennan*, 511 US 825 [1994] at 860).

¹⁴ Approximately half of the states in the US privatize healthcare services in their state correctional facilities (Beth Kutscher, "Rumble over jailhouse healthcare," *Modern Healthcare*, August 31, 2013, <http://www.modernhealthcare.com/article/20130831/magazine/308319891>).

¹⁵ See *West v. Atkins*, 487 US 42 [1988].

¹⁶ See *Madrid v. Gomez*, 889 F. Supp. 1146 [1995] at 1280: “Conditions in the SHU may well hover on the edge of what is humanly tolerable for those with normal resilience, particularly when endured for extended periods of time. They do not, however, violate exacting Eighth Amendment standards, except for the specific population subgroups identified in this opinion.”

¹⁷ *Ibid.* at 1279.

¹⁸ For a Supreme Court case that establishes deference to institutions in determining prison conditions and rights afforded to detainees, see *Bell v. Wolfish*, 441 US 520 [1979] at 546: “Maintaining institutional security and preserving internal order and discipline are essential goals that may require limitation or retraction of the retained constitutional rights of both convicted prisoners and pretrial detainees.”

¹⁹ *Estelle v. Gamble*, 429 US 97 [1976] at 106.

²⁰ *Atiyeh v. Capps*, 449 US 1312 [1981] at 7.

²¹ See Wendy Brown (2002) for a description of a similar paradoxical legal scenario in the case of identity politics and women’s rights.

²² *Spicer v. Williamson*, 191 N. C. 487 [1926] at 7, cited in *Estelle v. Gamble*, 429 US 97 [1976] at 104.

²³ *Ruffin v. Commonwealth*, 62 Va. 790 [1871].

²⁴ “Petition to Support the 22 Demands of Prisoners at Coal Township (PA),” accessed July 5, 2016, <https://www.change.org/p/pa-department-of-corrections-support-the-22-demands-of-prisoners-at-coal-township-pa>.

²⁵ Lee, David. “Capturing History: Imprisoned Men at SCI Coal Township Stand on the Right Side of History,” accessed July 5, 2016, <http://www.decarceratepa.info/voices/capturing-history-imprisoned-men-sci-coal-township-stand-right-side-history>.

²⁶ “SCI Coal Township Retaliates Against Prisoners Who Participated in Food Protests,” accessed July 5, 2016, <http://decarceratepa.info/content/sci-coal-township-retaliates-against-prisoners-who-participated-food-protests>.

²⁷ “Engaging in or encouraging unauthorized group activity” and “possession or circulation of a petition” are considered Class I misconducts requiring an internal disciplinary hearing process where a hearing examiner determines guilt or innocence based on the preponderance of the evidence, a lesser legal requirement than for assessing criminal guilt, despite the fact that these are technically criminal charges. If found guilty, an inmate is removed from his job assignment and may also face time in disciplinary custody, loss of privileges, and fines. “Refusing to obey an order” is also considered a Class I misconduct but is eligible for informal mediation and variable punishment (Pennsylvania Department of Corrections Policy DC-ADM 801, “Inmate Discipline”).

²⁸ Joseph Bernstein credits the rise of these tactical units with the precipitous decline in prison riots starting in the 1970s and 80s, along with the judicial intervention and bureaucratic management of prisons (Joseph Berstein, “Why are Prison Riots Declining While Prison Populations Explode?” *The Atlantic*, December 2013, <http://www.theatlantic.com/magazine/archive/2013/12/have-a-safe-riot/354671/>).

²⁹ See for example *Austin v. Pennsylvania Dept. of Corrections*, 876 F. Supp. 1437 [1995] a class action lawsuit whose medical challenges included the lack of healthcare staff, their inadequate training, and the profit motive from contracting to private healthcare vendors that resulted in untimely and inadequate care. The case was settled and the DOC was ordered to budget for more healthcare staff and provide an external peer-review system of quality assurance. While more staff were hired, the quality assurance program was short-lived.

³⁰ See (Hornblum 1998). See also Goldwin, Ron and Gar Joseph, “A Riot at Holmesburg Changed the Prison System Forever,” *Philadelphia Daily News*, June 10, 1988, http://articles.philly.com/1988-06-10/news/26267533_1_prison-system-prison-conditions-holmesburg-prison.

³¹ Schwartzapfel, Beth. “A Primer on the Nationwide Prisoners’ Strike,” accessed November 14, 2016, <https://www.themarshallproject.org/2016/09/27/a-primer-on-the-nationwide-prisoners-strike#.SI8RRVi7w>.

³² Malcolm X famously announced in 1964 and then wrote in his autobiography, “[t]he white man is not inherently evil, but America’s racist society influences him to act evilly. The society has produced and nourishes a psychology which brings out the lowest, most base part of human beings” (1964:378).

³³ Referring to Michelle Alexander’s popular book on the racial politics and racism of the War on Drugs, *The New Jim Crow*.

³⁴ In the book’s preface, Jean-Paul Sartre emphasizes Fanon’s radical call to violence; however, in a foreword added to a later edition, Homi Bhabha tempers this interpretation (see Fanon 1963).

³⁵ Although it was relatively rare to hear healthcare providers directly recite legal precedents and terminology like Dr. Keller did, it was clear how these constructions took form in the provider’s attitudes toward patient evaluations and the desire to evade lawsuits.

³⁶ See *Johnson v. Harris*, 479 F. Supp. 333 [1979].

³⁷ For the following disease processes over the course of my fieldwork: hypertension, cancer, diabetes, asthma, hyperlipidemia, HIV, and hepatitis C.

³⁸ Through the protection against “deliberate indifference,” the provision to equal access, and oversight from auditing organizations like the state Bureau of Health Care Services, the American Correctional Association, and the National Commission on Correctional Healthcare.

³⁹ Morbidity and mortality conferences are utilized in many teaching hospitals and medical centers to review errors in patient care and identify areas for individual and system-wide improvement.

⁴⁰ *Trop v. Dulles*, 356 US 86 [1958] at 101.

⁴¹ *Rhodes v. Chapman*, 452 US 337 [1981] at 347.

⁴² Loic Wacquant (2005) describes the process of civic death for inmates who are excluded from the social compact with regards to public services, political participation, and the accrual of cultural capital. Joshua Price (2015) extends Orlando Patterson’s (1982) argument about the social death enslaved Africans experienced to make a trans-historical parallel to the many social disruptions and acts of marginalization experienced during and after incarceration, including poor healthcare.

⁴³ See Fassin’s (2007) discussion of the embodied racial memory of apartheid in the experience of AIDS in South Africa. Harriet Washington (2006) demonstrates the historical significance of Tuskegee in a long American tradition of racist medical experimentation. In a recent publication, an estimated 1.4 year loss in life expectancy at age 45 for black men can be correlated solely with mistrust stemming from the public disclosure of the deceit in the Tuskegee experiments, to say nothing of the numerous other racial injustices and inequalities still influencing the health and healthcare of African American men (Alsan and Wanamaker 2016).

⁴⁴ See, for example, Bruce Western: “[Mass incarceration] is a profound social exclusion that significantly rolls back the gains to citizenship hard won by the civil rights movement” (2006:6) and Michael Tonry: “Rising crime rates in the 1970s and 1980s, compounded by anxieties associated by rapid social and economic changes, including the fruits of the civil rights

movement, made Americans anxious and eager for simple solutions to complex problems" (2011:10).

⁴⁵ In her ethnography on psychiatric care in supermax prisons, Lorna Rhodes refers to an "economy of attention" (2004:35) that inmates insert themselves into through a "surplus of power" created as the embodied remainder of what the control apparatuses of the prison cannot adequately securitize. I find that a similar language is appropriate here because it captures how the legal construction of suffering leaves behind a lived remainder that is both productive within and outside of courts, but also unproductive or "useless," to use Emmanuel Levinas' (1998) phrase.

Chapter 2 – Contracting Care: Healthcare Privatization Inside-Out

So his motivation was not just to provide quality services, his motivation was to see if there was a *business* that he could grow. And it was natural in correctional healthcare.

- Marion, on contracting healthcare services to Philadelphia jails in the 1980s

Doing Well While Doing Good

Sitting in an office conference room at a business park in the suburbs of Philadelphia far from Graterford, I found myself surrounded by business and philanthropy awards, commemorative magazine covers, and inspirational posters with Martin Luther King, Jr. and other civil rights heroes on them. I was meeting with Marion Gordon, the general counsel for one of the first companies to provide contracted healthcare services to the Philadelphia jails in the 1980s – a model that was subsequently adopted across the state by the Pennsylvania Department of Corrections. She also happened to be the daughter of the physician who started the company, a “black, family-owned operation.” As we sat in the conference room, she unraveled the history of prison healthcare privatization in Philadelphia – its contradictions, logics, values, and moral dilemmas – and how her father’s company ultimately left the correctional healthcare industry. Her story reflects the process of how privatization of state healthcare in Pennsylvania’s prisons, too, was “natural” as she states in the epigraph. Privatization relied upon the convergence of legally-mandated care and profit, including the expectation of efficiency in the market, reduced costs, and a decline in litigation. This history, together with providers’ professional narratives, also demonstrates how permeable the hard, stone walls and steel bars of prisons are, where the market logics of managed care seep in and out of the institution.

In this chapter I begin by telling Marion’s story of healthcare privatization in the Philadelphia jails and highlighting the commonalities with the companies operating in Graterford that contracted healthcare during my fieldwork to highlight some of the

imagined gains from privatization and the logics that operate around budgeting for prison healthcare and accruing profit. Then, I move on to give an ethnographic vignette that demonstrates how cost management under a private healthcare firm functioned at Graterford through a “utilization review” process. This process placed providers in the position to have to argue for care that reproduced the division of care by condition and the legal obligation for the treatment of “serious medical needs.” The review process made use of the euphemism of an “alternative treatment protocol” that delayed care until the company could either defer the cost to the state or would become legally obligated to treat an inmate. These processes of deferral placed inmates along a trajectory toward “serious medical need,” allowing them to suffer until a significant enough threat to their lives warranted the mobilization of the prison’s resources. Finally, I describe some of the healthcare providers’ reasons for working in the medical profession, and how practicing medicine in the prison did or did not fulfill those reasons. I show how, both through providers’ histories, the utilization review process, and the logics of managed care that operated both inside and outside the prison, the seriousness of inmates’ health needs was diminished and normalized by referencing legitimate suffering as something that occurred elsewhere, outside of prison. Although I punctuate the exposition in this chapter with inmates’ perspectives on contracted care, their experiences under the regime of private healthcare vendors as wards of the state come through elsewhere in this dissertation. For this reason, I focus mainly on the how the conditions of contracted care arose and how medical practitioners perpetuated them.

Marion began the origin story of her father’s company by telling me how, in 1988, there was a federal court ruling on the overcrowding in the Philadelphia jails and the death of an inmate in custody. The scrutiny surrounding the death amidst the conditions of overcrowding and the financial burden of overcrowding itself led a judge to deliver a consent decree for provisions to resolve overcrowding and encourage inmate safety. Marion described how her father was then contacted as part of the settlement agreement:

So when this death occurred, they reached out to my father who was then a successful physician who had begun in one office in South Philadelphia and expanded to six... and was skilled in treating an at-risk population, because these medical centers were all in underserved areas. So, on the premise that the same people who he was treating are ending up in the [jail], he was asked to come in and help recruit physicians and physician assistants to supplement the city staff. So what I'm trying to describe is that the climate was one of a lot of *scrutiny*... from the court, from inmate advocacy groups, and so the city sort of raised its standard in '84-'85 and said, "You know what, we need to increase our provider staffing at the [jail]."

She described a situation in which her father's firm, as a group of local providers, was recruited to provide services because they had skill in treating the same population that was being incarcerated. Race turned out to not only be a factor in the city's decision, but it also became important for states and other municipalities as the company started to grow. Marion stumbled somewhat over her account of the importance of race in navigating the goal of making profit and their identity as a small company:

The fact that it was a black-owned company was *definitely* a distinguishing factor. That was *hugely* distinguishing. And we might even say, you know, and we have more sensitivity to the population because we're... *black*. You know, I mean that, too! I mean, we didn't really exploit that one because we were, uh... we are entrepreneurial. We are not like, you know, pro bono. So we were trying to make money from it, you know, so I think that even when we.... I think that size does matter, is what I'm saying. But, the other thing about size, the big ones have experience. They have maybe five state systems. We had two, for example.

Marion drew a distinction between larger-sized companies that afforded financial resources and wielded the desire to make profit and smaller firms that had to market things like race or community belonging to get bids but were assumed to be more altruistic as a result. Within this schema, she awkwardly distanced herself from the issue of race when it came to making money, but described how the company used it to their advantage to make the argument that they were better suited to cater to the needs of the inmate-patient population. As the ultimate fate of the company would evidence – it later merged with two other companies and was bought out by one company, Prison Health Services, that would then go on to provide healthcare for the PA DOC – the practice of

privatization commodified race and local knowledge (that was sometimes coded language for race), uprooting and incorporating it into larger, for-profit companies that operated across multiple states. In this sense her distinction between racial makeup and size turned out to be true, as her company was bought out and the staff replaced largely with white men.

While Marion admitted that entrepreneurialism and profit were central to their model (juxtaposed with the abundance of philanthropy accolades in the conference room), she also contended that this was not necessarily at odds with humanitarian intervention in such an underserved population:

[My father] used to always say, “You want to be able to do good and do well,” so the “do good” part is providing quality health services: diagnosing, treatment ... and familiarity with that population. So I think he was motivated in an altruistic way. I also think he was – he saw a business opportunity. He saw a trend in the industry, and he felt like he could assemble... with his network of providers, he could assemble a team, and that’s what he would do.

In the 1980s, health maintenance organizations (HMOs) and the model of managed care began in a non-profit, cooperative-like model and became marketed the business sector as a way to cut the cost of providing employees insurance coverage under the employer insurance mandate. While managed care initially focused on preventative care and integrated networks of providers, the emergence of for-profit managed care organizations put pressure on contracted providers to cut costs, introducing more healthcare rationing (Rylko-Bauer and Farmer 2002). Managed care was heralded as a more efficient way of regulating social welfare – to both improve healthcare services and generate economic growth, a promise that has not been realized (Sullivan 2000; Waitzkin 2000).¹ For prisons, privatizing to create efficient healthcare was a way for the market to attempt to solve a problem created by the political economy of punishment in the United States over the prior two decades that resulted in prison overcrowding, seeking solutions in the market to problems that were caused in part by the state’s broader divestment in social services (see Wacquant 2009).

At Graterford, as in the rest of the state of Pennsylvania, efficiency in prison healthcare services was initially sought mainly through providing more ancillary services like x-rays and labs within the institution, and deferring primary care responsibility to mid-level health care professionals like nurse practitioners and physician assistants.² As contracts diversified, however, laboratory and pharmaceutical services became sub-contracted. This resulted in situations where, for example, the lab samples from inmate-patients at Graterford had to be shipped to Michigan to be processed and analyzed, resulting in a minimum of a five-day turnaround. Providers would joke (although it was true) during clinical rounds in the infirmary, “A STAT lab around here means about 3 days.” If they needed to know lab values for a patient with any degree of urgency, they were left with the decision to hospitalize him or wait for the sample to be analyzed through their lab vendor.

In addition to the commodification of “local” knowledge, humanitarian concern, and cost efficiency, privatization placed value on the displacement of litigation for prison health concerns, as well. The history of Marion’s father’s company being recruited in response to the legal obligation to care for inmates, the need to manage costs for a burgeoning prison population, and the broader trend toward managed care at the time indicates how the industry of private correctional healthcare emerged in part as a response to the legal obligation for care at an inflection point in the exponential growth of the prison population.³ Right at the outset of our conversation, Marion described the logic of privatizing in relation to the legal obligation for care. “The purpose of privatization,” she said, “is so that the state actor can predict their costs and delegate its legal duty of providing these services to a private actor or company. So, inherent in that idea is the fact that they also have to pass on those sort of legal duties and obligations they have to the inmates.”

While, as I mentioned in Chapter 1, contracting the state’s obligation to provide healthcare to a private company did not mean that the private company was immune to federal law,⁴ Dr. Keller outlined how the capital backing of a private company could help protect state institutions from legal liability. When I spoke with him about how one of the challenges to caring for an incarcerated population was the increased rate of litigation, he

outlined his take on the content of and motivation behind inmate lawsuits. His response displaced the profit motives onto lawyers and inmates and demonstrated how far companies – in this case Wexford Health Sources – were willing to go to set a precedent that inmates not sue:

Nick: So [inmates] file more lawsuits than people in the community?

Dr. Keller: Much, much, much, much more. Much more, and probably part of that is that they have nothing to lose and so if they can find an attorney that can represent them for some quick gain, they will do that. Obviously, I don't think it's to their gain because they're in here. Maybe it's more to their families gain, I don't know. But I think that [*pause*] they know the system. And I think they figure if they can find somebody... Now obviously, legitimate things happen, and that's no different than out in the community. People get hurt, things go wrong, sometimes it's a physician's fault, sometimes it's not, but the system allows people to try to figure that out with a lawsuit, depositions, figuring out who did what, who is at fault, and is there some kind of monetary way of paying back that fault. But more so in the corrections system. These guys have a lot of time on their hands. They can read in the law libraries, you know, have all this information and try to figure out for themselves that they can put a lawsuit together. And maybe if it's something small, the company will just want to settle out-of-court and not take it to the nth degree.

And usually that doesn't happen. Usually the companies don't want to set a precedent of giving in to everybody with some minor lawsuit, and they're willing to spend the money to get it thrown out... to put it out there that "we're not gonna settle," you know, and "we're gonna go the whole way until you get nothing." And in fact, according to what I've been told, you know, many of the cases that are put out there and getting thrown out.

Nick: And how does that work? You said they were willing to spend more money to have it thrown out?

Dr. Keller: Well, the vendor, whether it's the state or the medical vendor... their legal department is willing to look at these cases, and they're willing to spend the money that they need to for depositions or trial, so that there is no... They would rather go to trial or go through the discovery system and see if the other attorney is willing to drop the case because there is – it's frivolous, and for the attorneys for the inmates to file these kinds of lawsuits and hope that because they're asking for minimal amounts of money, that they will just want to settle to make it go away. And most of the vendors that I have worked with have said "No, that ain't gonna happen. If we have to spend more than we're supposed to, we're gonna spend it on our legal fees and whatever we need, but we are not going to give in

and set a precedent that were going to settle out-of-court on a lot of these frivolous cases. We'll push them to the limit so that the inmates go back and say, 'You know we better have a good case, because these guys are going to fight us tooth and nail, they're not gonna give in.'"

Companies also provided healthcare practitioners' malpractice insurance as a way of leveraging financial resources to defer legal responsibility. When one healthcare vendor lost its contract with the state and another company came in on an emergency contract, some providers were concerned that they would lose their coverage, or that the company would not provide extended insurance coverage. One of the providers even threatened to stage a "walk out" of the institution if the departing company refused to provide the coverage. When I asked if she thought it was ironic that she could protest her loss of malpractice insurance but inmates were not allowed to protest their healthcare, she replied, "No way! We need to be protected from them, not the other way around!"

In this way, the managed care movement transformed the response to litigation and prison policy into a business opportunity supposedly distinguished originally as a form of "humanitarian" capitalism that had broad-reaching effects not only on the provision of healthcare itself, which will become more apparent below, but also on every other structural aspect of the delivery of care in prison settings.

"At Risk"

A distinguishing feature of the quarter billion dollar contracts that private companies bid for with the state was their basis in actuarial models of inmate health. Marion described how, in reality, especially if one limited the rationing of healthcare services as much as possible, it was nearly impossible to profit off these contracts because the actuarial models were imprecise and could not effectively account for "catastrophic events" (an industry term for unexpected, expensive, and typically acute illness or injury). Healthcare vendors were therefore not well equipped to handle unexpected costs. When the DOC began the *post hoc* implementation of its Hepatitis C protocol referenced in the introduction, it was costing them \$86,000 per inmate who was enrolled. As a way of offsetting that cost, the DOC partnered with a university that had a

subsidy grant to provide HIV care for inmates, which required bussing inmates throughout the state to the university to receive their HIV care.

For these reasons, when I was discussing the contracts with Marion, I was caught off guard when she mentioned the phrase “at risk” to describe the process of being vulnerable to these unexpected health events and the consequences of reallocating funds based on actuarial data. My mistake was that I was unclear on who, exactly, was “at risk.”

Marion: Care was paramount, even if at times it cost us, you know, money.... which it did. It was *very* difficult. When you go at risk, unless you have enough money, it's very difficult because the range of services are so much, and the acuity, you know, the illness of the population is so severe that.... But you know you do base your proposal on data. So I can't say that we were, you know, hoodwinked, or whatever. You know we went into it knowing what it was. We did a decent job. [...]

Nick: Yeah. Can you say more about – you said when you go “at risk.” Can you describe what that means? Or are you just referring to the fact that it is an at-risk population?

Marion: No, no, no! Not an at risk *population*, I'm saying an at-risk *contract* because, so... the way you determine the price is they determine it on what's called a per diem rate, the per inmate per day price, and that's based on a lot of different data. So you look at the pharmaceutical utilization, and you look at all this data to determine what is your per inmate per day rate that you can provide the service, and maybe you add the profit on top of it, I don't know. But, that is the way it's calculated, so you look at say 500 inmates at a per inmate per day rate of \$350 and that \$350 includes sort of like an insurance rating, you know from the time of arrest to the time of release. [...] So, um, when I say “go at risk” I mean that you get this, like \$12 million,⁵ and you spend it down, and you provide these services. You pay 500 people, you pay all these providers, you pay these hospital bills, right? You pay surgery, outpatient surgery bills, you know, you pay all this stuff with this amount of money, and if you're able through the UR [utilization review], quality assurance, and your controls, and your physicians don't *over refer* [*sighs, rolls eyes*] you know what I mean?⁶ So all that. If you're able with all these different cost drivers, to keep them in control, you may be able to make money. If you don't keep them in control, you lose money.

The per inmate per diem rate was another source of the anxiety over the contracts and presented a moral dilemma to Marion because it assigned a literal monetary value to

the life of inmates. Along with the fact that it was difficult to make a profit contracting correctional healthcare services, especially as a smaller firm, Marion cited this ethical dilemma as a reason why her family eventually sold the company. When speaking about a juvenile detention facility that the company operated within, Marion mentioned how, rather than a set contract based on projections, the company that operated the facility paid the healthcare firm a per diem rate based directly on the detention center's census:

Marion: We were losing money because the census wasn't up, but we're a *black-owned company* with sort of, a *consciousness* around... what's going on. And so I actually had a moral dilemma, so ok for us to be successful as a company, we basically have to get more people, more of these black and brown kids arrested? [laughs]

Nick: Yes. Right!

Marion: Right?

Nick: Yeah.

Marion: So that we can make our census?! This is crazy! That's crazy. It's a ... you know, so ... I didn't like that either. That part was, I found, challenging.

It was difficult for Marion to ascertain where to draw the line between profiting off of healthcare rationing versus profiting off of the incarceration of black and brown people (or, perhaps more accurately, black and brown "kids"). Her attempt to rationalize her understanding of mass incarceration, which she glosses above as "what was going on," as humanitarian capitalism only goes so far. The profit that healthcare companies made off of managed care in the prison contributed to the process of inmate subject formation as wards of the state who were the state's property.

Similar to the reference to experimentation with respect to letting diseases progress to the point of the legally-obligated point of intervention, inmates also saw this form of economic control and exploitation as experimental. Referencing the dermatological experiments conducted at Holmesburg Prison in Philadelphia,⁷ Eddie mentioned how protections for inmates participating in research had made that form of exploitation and

explicit experimentation forbidden, so the state and private companies had to adapt and experiment on inmates in more subtle, economic ways that were ultimately criminal:

It's not that you can't do those [experiments] now. You just have to be more clever about it now. Things aren't crazy like they were before. People aren't dumb, they gotta be smarter. The things they have to do to make money, to save money, in these institutions. It's not as overt. You're not getting no patches across your back now, and test you like you a guinea pig now. They gotta come at you a different way now. They have to be more sophisticated. No doubt in my mind that things that happened to me in here that I don't even know has happened to me. In the medical department. Ain't no doubt in my mind.

You got some people that say whatever happen to them while they in there they deserve it. No we don't. You're talking about a human being. We don't deserve to be cheated and whatnot, like I said when we started off with that tv thing and these proprietors and whatnot [discussing overpricing of items in the prison's commissary and services like mail and phone calls]. We don't deserve to be cheated on this phone situation, charging us exorbitant amounts, overcharging us for certain services. We don't deserve that. You called me the criminal, now you becoming the criminal!

Eddie therefore not only challenged the logics that placed him as the property of the state off whose back profit could be derived, but challenged the notion that he and his fellow inmates could so easily occupy the role of criminal while corporate criminal acts were perpetrated with impunity (see also Hagan 2010). Darrin, the thin, bald man I introduced in Chapter 1 who sued for access to his medical records even mentioned that he wanted to try to recuperate some of the corporate profits that were made in a system that exploited him and perpetuated his ill health, suggesting that if he could not benefit from being healthy, perhaps he could benefit from being a shareholder:

I'm not gonna lie to you, I told my family some years ago, I said get some stock in Corizon, PHS... it's on the ticker. While I'm here you better benefit, you know, long term. I said, "You gotta think about my nieces and nephews." set em up. Set em up for college, set em up for life! It sounds... kinda bad. But the reality is, a lotta people are invested in this place, a lot of politicians, a lot of religious people, a lot of lay people. This is like when ... when the advent of slavery actually started growing. People started investing. There was a lot of money, so people started investing in, everything that had to do with that *lifestyle*. People made tremendous amounts of money off that. And this... this is the *repackaged* part.

In reality only few of these corporations were publicly traded, so even the opportunity to profit off of the rationing of their own care was not made available to inmates. Darrin's direct reference to the repackaging of slavery into a form that extracted profit from inmates directly mirrors David Oshinsky's (1996) presentation of the claim that convict leasing after the turn of the twentieth century was "worse than slavery," because enslaved Africans, when cast as property, had value to those who enslaved them and they were cared for. Convict leasing, on the other hand, produced a massive labor supply that had more value in the rapid turnover in supplied labor than individual value. Similarly, inmates had more value in numbers to private healthcare firms. Rather than boats or other marketable goods, the products of the "labor" they performed in sickness were measured in profit margins. As Marion mentioned, however, it was difficult to actually make money given all of the contingencies of providing healthcare to an incarcerated population not taken into account by the data that drove their five-year budget proposals, but unfortunately while they continued to go "at risk," inmates experienced risk in spades.

Not-So-Collegial

Over the course of my three-year involvement at Graterford, there were three distinct companies who were contracted to provide healthcare there, despite the fact that these contracts were for five-year periods. The first company, Corizon Health, ran out the term of its contract and was outbid by the second, Wexford Health Sources. Wexford's contract was terminated as a direct result of the low bid that it offered to beat out Corizon in the open bidding process. Typically these low bids made it such that the company then returned to the state asking for more money that it would not provide or the company had to cut extreme costs to avoid financial loss, and the deficiencies in the care resulted in upticks in lawsuits and inmate-filed grievances. The latter happened to Wexford, which lost its contract in 2014 and was replaced by an emergency contract with a smaller, newer company called Correct Care Solutions, which went on to win the open bidding process. As Marion discussed, the companies usually kept the staff as a gesture of goodwill and did not replace them wholesale when they took over a contract. The result was some

continuity through healthcare vendors, but the turnover rate was already high for providers who left to pursue other, “real” state jobs with state pensions and benefits or entered private practice. During the period of my fieldwork, the attrition rate was approximately half.

In an effort to contain costs, all of the companies implemented a “utilization review” process for specialty care, outside consults, and imaging that could not be done within the facility. One company, Wexford Health Sources, made use of weekly teleconferences with the medical director, a corporate director, administrators, and the prison’s healthcare staff to review the providers’ requests on behalf of patients. Wexford called these meetings “collegial,” in an attempt to index a consortium of expertise. However, Lance, the tall, white, middle-aged physician assistant, highlighted the irony in the name: “They call it collegial, but it doesn’t seem so collegial! You really have to plead your case to these guys, and it’s all up to them whether or not they want to approve it.”

The meetings themselves took place in a rather symbolic location. A few years prior, as the Department of Corrections was starting to realize cost reductions from privatization and seeking to further streamline their resources, they decided to consolidate certain specialized services in certain facilities, which they called “centers of excellence.” In this way, inmates needing renal dialysis, for example, would all be at one institution that provided that medical service, reducing the need to hire more specialists and coordinate care across multiple facilities. Graterford had a chemotherapy suite in its infirmary, and when I started my fieldwork, it was in consideration for the position of an oncology center of excellence. However, due to the logistics of consolidating care, transferring inmates to specific facilities, and the cost advantage discovered in doing oncology visits through telemedicine, Graterford’s oncology suite went vacant. It then came to serve as temporary administrative office space, storage, and a meeting location – a former space of healthcare delivery transformed into a space to negotiate denial and deferral of care operating elsewhere.

Dr. Diallo, Ghanaian American cardiologists with a tall, overbearing presence, who spoke in a low monotone, was the acting medical director at the time. Prior to the

meeting, he had lectured the providers on how to fill out the consult forms to make their case to the corporate director:

I don't want to see a consult with one line, you know, "Chiropractor, need x-ray." No! "33 year old guy, fell down into a train track, broke his arm. I need an x-ray." You know, something like that. I need a story that an idiot could pick up the consult for him and see why you're asking for whatever it is you're asking for. No more one-liners! [*pause*]

I gave Dr. Atwal a consult that I wrote out today.... I had a story – what the patient was, what I wanted. I had the right thing circled – off site, on site. I had his date of birth, I had his name – last and first. It's not that difficult. It'll take you another minute. The tasks that we do are really quite simple. I understand sometimes it's tedious, but let's complete the task that we start. Let's not do it half... half-assed.

Dr. Diallo's version of the consult request contained no more medical justification or medical specificity, but conveyed that what he thought was needed was a "story," something that would be easily understood by a non-expert and could be easily replicated within the confines of the mundane bureaucratic requirements of prison healthcare.

The Wexford representative was late calling in, so this left time for the providers in the room to express their hostility toward the process and to discuss other strategies for making their cases to Wexford. Lance said that the inmates did not realize or understand how much the providers "go to bat" and "fight" for them in these meetings. Dede, a young nurse practitioner fresh out of school, said that she did not want to discuss her patients and was anxious that the representatives would make her feel incompetent and like her treatment recommendations were unnecessary.

Thirty minutes past when the meeting was scheduled, the Wexford representative finally phoned in. The administrator on our end told him that the meeting would have to be quick because the Graterford providers had to be on another conference call in an hour. The corporate director, himself a physician, said that he had not had a chance to review all the requests, but hoped they could get through all of them. The providers in the room all rolled their eyes and groaned inaudibly. The review process started, with the Wexford director bringing up the requests laid out before him, calling out the inmates' names for the providers to follow along and answer questions as they arose. He could be

heard shuffling through the papers as the cases were discussed, stamping multiple forms and scribbling out his recommendations.

The first case was Mr. Robbins, a smaller, black inmate in his 30s who was frequently housed in the mental health unit. He had shut his finger in a cell door two months prior – an act many of the providers alleged was on purpose. One month after, he had been sent out to Hahnemann Hospital in Philadelphia where he was told there was not much that they could do to fix his finger because the follow-up care would be too extensive to be feasible in the prison. I was in the dispensary the day he returned, when he swallowed a mechanical pencil so that he could go back to the hospital. He told the providers about his rationale, ultimately rationalizing his behavior by reproducing a psychiatric designation he had been given: “I saw that pencil and started thinking about how they weren’t going to fix my hand. I just kept thinking about that, so I figured if I swallowed it, maybe they could take me back to the hospital and they can fix my hand? I guess I have poor impulse control.” That day, the providers decided to send him back to the hospital to have him evaluated and to minimize the risk of the pencil perforating his stomach, referencing a case where an inmate swallowed batteries and subsequently died as justification for their decision. Mr. Robbins went back to the hospital and had the pencil removed endoscopically, but his hand remained untreated. Frustrated and desperate, Mr. Robbins tried to chew off his gangrenous finger, but was not successful.

Dr. Atwal presented the case to the director: “Mr. Robbins has a right little finger. He chewed it, and it got infected. Now he has osteomyelitis. That thing has to come out. He has to have amputation right now. He’s on IV antibiotic, vancomycin and zosyn, almost four weeks.” The director stated that he wanted the providers to be “on the ball” with Mr. Robbins’s post-operative care so that he did not harm himself any more: “We certainly don’t want to make it any worse post-op.” I heard him stamp his forms as he approved the request for amputation, and I felt relieved and almost grateful that it had been approved, counting it as a victory against his ongoing sepsis. At the moment I was more impressed by this approval than surprised or affected by the fact that the broader management of his case and the refusals he faced had produced or become entangled with his “poor impulse control” and bodily harm. The erasure of this management through the

framing that his infection was caused by his attempt to chew the finger off and not by the original inability to have it surgically repaired and it would now be taken care of came to be epitomize the ways these approvals operate to normalize managed care in the prison.

A few more cases passed and were approved with some shuffling of papers to make sure the providers and the corporate director were in sync, and the forms were filled out properly. A young inmate, Mr. Poole, who had sickle cell anemia, then came up. The consult was for urology to recommend management for his recurring priapism, a condition frequently associated with sickle cell where the altered shape of the red blood cells inhibits blood drainage from the penis and results in a sustained and painful erection. While waiting for the consult to be approved, Mr. Poole had actually suffered a sickle cell crisis and was hospitalized at the moment, confusing the director:

Director: Priapism... Am I reading this right, that he was... ?

Dr. Diallo: Yeah, he's still in the hospital with... slowly recovering from a sickle cell crisis. He's been a tough manage. I spoke with the hospitalist who is taking care of him, and... he's received multiple transfusions. He's not ready to come back, yet, so...

Director: Oh, ok. So he's not even in your facility today.

Dr. Diallo: No. Right. He went to the hospital about... I guess about 10 days ago and is still there.

Director: Still there. Oh, ok. We should defer this. Why don't they have him see the urologist while he's in the hospital?

Dr. Diallo: Um, I can try to get that done. I don't know how successful I'll be, but I'll touch base with the hospitalist and see.

Director: Good. In the hospital, that'll be the best access to urologists. That'd be the easiest.

Relevant to Mr. Poole's and Mr. Robbins's treatment is the stipulation in Wexford's contract with the state that Wexford pay for specialty care, and that state Medicaid funds pay for emergency hospital visits and outside hospital treatment. Thus, Wexford did not pay for Mr. Robbins's emergency trip after swallowing the pencil, nor

for Mr. Poole's hospitalization and transfusions subsequent to his sickle cell crisis, but they would have to pay for an off-site urology consult as well as any on-site treatment and follow-up care in the prison. The desire to obtain a urology consult during this hospital visit was a way for Wexford to literally pass the buck for specialty care, relying on the point of emergency of his underlying illness in order to do so, whereas inmates, through the structuring of clinics around "serious medical needs" like diabetes and hypertension, were not afforded the opportunity to group their care together in such a way.

Likewise, the inability or unwillingness to provide adequate post-operative care resulted in inaction toward Mr. Robbins and the desperation to chew off his own infected finger. Dr. Diallo knowingly chuckled at the director's suggestion that obtaining a urology consult would be easier in terms of access during his hospitalization. He nodded as he laughed in a way that indicated to me that he knew the underlying logic was to save money, and that the director's reply was both expected and clever. Despite this reaction, Dr. Diallo committed to pursuing the consult while Mr. Poole was in the hospital.

The next patient discussed was Mr. Perry, who was having lower back pain and trouble urinating. Some suspicion had arisen for cauda equina syndrome, a serious neurological compromise of the nerve roots of the lower spinal cord, usually requiring swift surgical decompression, so they discussed his case history and the need for imaging:

Director: This is a request for ... MRI.

Lance: Originally I had requested for a urology consult, but the, uh, he was previously recommended for the MRI because they wanted to rule out cauda equina syndrome, so...

Director: Alright. Somebody put a note on here that the patient *had* an MRI in September.

Lance: That I can't tell ya.

Dr. Diallo: That's possible.

Director: Yeah, I guess.... We paid a bill! We paid for it. I sure hope he had it. I don't have a report, but somebody sent us the bill for doing it, and it was paid. What's the date... 10th of September.

Administrator: Yeah, I see on PTRAX [the electronic scheduling system] that he went out on September 10th for an MRI.

Director: Ok. How about let's ATP this one. Let's get that report.

Lance: Sounds reasonable to me.

ATP, I would later learn, stood for "Alternative Treatment Protocol," usually a delay of the original request accompanied with some form of interim management, monitoring, or repetition. In this case it represented a re-evaluation of the case and a review of an MRI that had taken place six months prior, in a situation that might require emergency care. Framing the plan as an ATP rather than a repeated imaging study made the situation immanently "reasonable" to Lance.

The next two cases caused a lot of administrative confusion as those on both sides of the phone line shuffled through their paperwork to find lab reports, physical therapy notes, and hospital discharge summaries that were missing. The corporate director asked questions about treatment recommendations from other consultants that were unknown to the provider staff, so the providers reported what was most likely to have the consult approved. In one case, the director asked if the request for imaging was necessary, or if physical therapy was recommending that the patient continue with them. Dr. Diallo mentioned that he thought the patient was discharged from physical therapy, and another doctor had recommended further testing. The director approved it, but expressed his suspicion: "Ok set him up. In the future, I'd really like to have that physical therapy note."

Another case represented how misplaced paperwork and confusion affected the negotiation and approval process. The patient's history of not attending one of his prior visits also resulted in the director's tenuous suggestion that the patient could (or should) refuse treatment for the consult under discussion:

Director: It doesn't look like there's any note from the optometrist. This is just a routine eye check?

Administrator: That's what it looks like, yes.

Director: What's the underlying... do they have glaucoma, are they diabetic? What's the...

Administrator: Glaucoma.

Director: Glaucoma?

Administrator: Yes.

Director: Have they been to the glaucoma clinic at all?

Administrator: [*speculatively*]...Yesss.

Dr. Diallo: Are you sure he has glaucoma?

Administrator: That's what it says.

Dr. Diallo: It looks like two cataracts.

Administrator: Yeah, well it looks like a glaucoma follow up here.

Director: If he went to clinic, when was the last glaucoma clinic?

Administrator: Well apparently the inmate refused his visit in November... but he had an appointment with the doctor in March... that he went to... and hasn't seen anybody since then.

Director: Ok. Sounds like we need to try to get him to clinic again. Try to convince him to do it.

Administrator: Ok.

Director: He has the right to refuse. Ok. [writing out loud] ATP. Defer to glaucoma clinic. Check.

The next case also had misplaced paperwork that was needed to demonstrate the patient's history of receiving epidural injections. The director suggested that before proceeding, the providers should have the inmate tell them where he had received the

injections before and get him to fill out a release of information so they could obtain those records. Despite the fact that the loss of records and incomplete documentation were pervasive in this process, this – as in other cases – served as an opportunity to displace the providers’ errors onto the patient, making it seem like he was trying to manipulate the provider into getting the injections without himself proving that he had received them on the outside in the past. Similarly, the patient’s missed appointment in the preceding case was used to simultaneously raise the point that he had made a wrong decision that should be rectified, but that he also had certain refusal rights as an inmate that were selectively applied. The process elided any positive right that he might have to deserve healthcare and instead suggested that the behavior might be encouraged to save the company from paying for those visits, whereas this right to refusal was conspicuously absent in the case of Mr. Leonard’s suicide attempt at the beginning of Chapter 1.

Lance presented the next patient, Mr. Newman, for whom there was a concern for sleep apnea. Of all the presentations, he came the closest to the typical, formal way patients are presented in many clinical settings:

Lance: This gentleman is a 43-year-old follow-up. His roommate is complaining of him having stopped breathing in the middle of the night and snoring absolutely terribly. He uh, weighs 325 pounds. He’s 5’8”. His tonsils are absolutely huge, so he has a reduced airway there. So... either an ENT follow-up or a sleep study for this gentleman.

Director: Ok. What the procedure generally is is to bring him up to the infirmary and monitor him overnight if he actually destaturates [if his blood oxygen levels go down].

Lance: [*pauses briefly and looks around, bewildered*] I don’t think we have that kind of equipment in the infirmary to do that.

Director: Well, uh... a pulse ox devise that the nurses use, to put on. And, just... watch it.

Lance: [*pauses*] Ok.

Director: It’s done at other facilities, so it shouldn’t be too hard.

Lance: Ok. Sounds like... sounds like a plan.

Director: Document it, and then we can do the more formal study. First we're identifying that there is a problem. Then we can do the study...if he actually has to correct the problem. So we'll ATP it until then.

Lance: [*obsequiously*] Thank you.

Director: Ok.

While the director stamped his forms, there was some backstage talk going on amongst the providers in the room that was muttered in a low voice so as not to be caught by the phone receiver. They expressed some concern with the clearly ineffective plan, and I took this as an opportunity to demonstrate my own concern. I said, "That's not right. You can't do that with a pulse ox. He needs a sleep study." Dede supported my statement: "They can't watch every hour, with what's going on in the infirmary. It's not feasible. That's not a sleep study." Dr. Diallo then attempted to rationalize the recommendation: "I mean, he's not going to be any worse off here than he is where he is now. So just put a pulse ox on him, document every two hours." Lance was convinced: "If it makes him [the director] happy, we'll do it." As opposed to other cases, in this case an alternative treatment was recommended that, judging by the director's comments, was also protocolized. However, in addition to being logistically infeasible, this alternative standard was not designed to capture the same symptom profile needed to make a diagnosis or – perhaps more importantly – to support Mr. Newman's breathing while he was sleeping if it were to stop.

A few other cases were then approved, mostly for imaging, some again conditional on receiving reports that should have been documented or included in the original request. Then we came to a review where there was some disagreement in how the case should be managed, and Dr. Diallo leveraged the knowledge of his patient's course of illness to negotiate the treatment decisions, albeit not as fully as he intended. The inmate, Mr. Lloyd, had a scrotal abnormality, and Dr. Diallo was attempting to get him seen by a urologist. The director did not feel like anything should be done, and the two ultimately compromised on repeating an old imaging study:

Director: The general rule is hydroceles⁸ are benign and best left alone. Didn't he have an ultrasound three years ago?

Administrator: Yeah it looks like he had an ultrasound back in 2010.

Director: You wanna repeat it?

[The director then expressed how he was confused about whether or not the physical exam and the prior ultrasound were conclusive for hydrocele, and if so, where they should go from there.]

Dr. Diallo: The only thing, doctor... I would say, I agree that most hydroceles are benign and best left alone, except when they become an issue from the perspective of pain, which seems to be the situation here. Um... he's had a scrotal support without much resolution in the swelling. And, pain continues to be an issue, which is why I think we might be a little more concerned with this than the average.

Director: Ok, so you're thinking that ultrasound would be indicated?

Dr. Diallo: I think so, doc.

Director: Well, so... if it's okay with everybody, what I can do is just cross off urology and change it to scrotal ultrasound. Does that work?

Administrator: Sounds good.

Director: Ok. Let's write scrotal ultrasound, and mark it approved. The radiologist doing the study should make a comparison to the prior study so we've got it on record.

After a while, a patient of Dede's came up. When the director mentioned his name, Lance gestured over to her and said, "You're up!" under his breath. Dede let out a silent groan and rolled her eyes, expressing her reluctance to discuss the case with the director. She looked nervous as the director started to review the patient's record. Dede was requesting that the patient see an orthopedist. He had fractured his thumb four months prior, and the x-rays were showing that his thumb had not completely healed, and he had not been back for a follow up after the cast had been placed. As the director looked at the x-ray reports, he mentioned the cast and then began reading off the report. The terseness of the interaction exemplifies Dede's attitude and approach to the process, as well as her intimidation:

Director: [reading off the report] Fracture faintly visible, not healing. It's taking a long time. Has he seen ortho before?

Dede: Yes. Ortho put the cast on.

Director: When was the last time he was back to ortho?

Dede: He hasn't been back

Director: Oh, ok. So since December he hasn't been back.

Dede: Yeah

Director: So it's currently outside the global period.⁹ For the future we have that 90-day global period. It would have been nice to have that follow up. Approved.

Dede let out a sigh of relief because her request was approved, she was not reprimanded more for being outside the global period, and the interaction she had feared was now over. There were a few more reviews, one of which was for an inmate that had since been transferred to another facility, prompting the director to joke, "It could well be that he feels perfectly fine now that he's no longer at Graterford." Afterward, the director concluded the meeting. According to the administrator at Graterford, there were still two more patients to review with orthopedic consult requests, but the director had not received the requests. There was a brief discussion about resending the requests and whether the director would review them independently or if they should be presented at the following week's collegial. Because the providers had another teleconference to attend, the director said he would review them in anticipation of next week or contact Dr. Diallo if he needed to.

Leaving the meeting, the other providers were generally pleased with how the meeting went and surprised at the number of approvals. While there was a sense of wanting to ration and more cost-efficiently control care, I too did not get the overall impression that the company was not committed to denying care outright, despite the fact that "ATP" was a euphemism for deferral or denial. With the exception of Mr. Newton's case, there was neither an alternative treatment suggested, nor were the suggestions that

were offered protocols modeled after community standards of care. The reactions and misrecognitions that we all had in this moment helps to demonstrate the effectiveness of the ATP tactic as a way to satisfy the providers' need for company approval of a treatment plan and the desire to get, as Dr. Diallo conveyed in his pre-meeting pep talk, stories across in a convincing way. The ATP acted as an empty signifier to satisfy those needs while forgetting the essence and stakes of the stories Dr. Diallo wished to convey – the course of illness for inmates. When these aspects did appear, they were transformed through various assumptions of inmate deservingness.

The ways that ideologies about deservingness, conflict avoidance, bureaucratic disorder, and company mandates came together in these conversational exchanges engendered a situation where concessions were made for what was considered acceptable or, to use Lance's word, "reasonable" care. Ultimately, these concessions hinged on the iterative – and ultimately rather mundane – process produced in these meetings (and elsewhere) whereby treatment deferral and denial were reconceptualized as small victories against the company's assumed desire to blatantly withhold care. These processes produce a form of collective "bad faith," obscuring the processual dynamics and final outcomes experienced by inmates-cum-patients (Sartre 1956).

Toward the end of Wexford's contract at Graterford I was discussing with an administrator the increase in grievances that inmates were filing that would ultimately contribute (along with going over their proposed budget) to their loss of the contract with the DOC. While he described many of them as frivolous, he mentioned that a lot of them had to do with medications being suspended and the delays that many inmates faced getting imaging studies. He finally turned to me and said plainly, "And so you've been in collegial enough, you can draw your own conclusions. When you hear "alternative treatment plans" it's... they're acting as gatekeepers." In deferring the point at which suffering becomes apprehensible under the broader legal system of rights in place to recognize it and declaring repetitive and ineffective tests as treatment, the ATP systematically altered the providers' own recognition of suffering, producing what Keshavjee, in his work on global health development programs in Tajikistan, calls "neoliberal programmatic blindness," (2014:16) in this case creating its own language for

non-treatment under managed care that structurally altered how providers and companies viewed suffering.

Ultimately the process of using an alternative treatment plan created the conditions under which inmates' illnesses would progress to the point of being legally legible through the standard of "serious medical need." When speaking of the counterintuitive logics of healthcare privatization in the prison and how serious medical need is produced, Eddie captured how it places inmates at a disadvantage with respect to their health and discursively obscures the processes that end in terminal or serious disease:

There's a flaw in that from the beginning. The gun goes off and they give other people a head start before the even let me go! I think there's a flaw even in the way you pick the company. They want to save that money! They're not gonna send you out for no \$25,000 or \$15,000 test or operation and whatnot, they want to prolong that stuff. And I believe it causes people health problems and cost people lives, that same practice. [*Assuming the voice of an administrator or company director*] "Well we gotta take another test to confirm that you have X disease because the first two was inconclusive." But the last one, that's the \$1500 or the \$3000 test so they want to hold off on that. Then when you are tested and they find out that you do have X disease there's nothing they can do.

I described in Chapter 1 that importing the logics of managed care into the prison transformed inmate copays. Rather than being an opportunity to exercise economic freedom, responsibility, or contribution to one's healthcare as its intended rationale under the governance of the market, its primary goal was to deter inmates from using healthcare services. In a similar irony, importing managed care, which started with the central tenant of focusing on bolstering preventative care, into the prison created delays and deferrals of care.

Compromises about treatment and the acquiescence to the structure of managed care reduced standards for recognizing the legitimacy to medical claims that fit neither the economic model to keep healthcare services within the institution or else result in hospitalization nor the legal standard of seriousness. Inmates like Eddie, whose amputation was the result of a delay in evaluation of gangrene that I discuss more in

Chapter 3, were then left to feel the effects as they waited for care that never came, came too late, or proved inadequate.

Inside-Out

Somewhat perversely, the same aspects of managed care that were reproduced and amplified in these meetings are what drove some providers to practice medicine in the prison in the first place and then became marketable skills in the context of managed care when they sometimes left the prison to pursue other job opportunities. Many providers began working at Graterford either when larger healthcare corporations bought out their private practices, the market for specialty care made it increasingly untenable to maintain a private specialty practice, or simply because of the dearth of job opportunities afforded to midlevel providers. Learning how to practice managed care in the prison setting therefore became sufficient training for working within the larger medical landscape. Although they sometimes discussed seeing the potential to include some of the caring and helping aspects that drew them to medicine in their practice at Graterford, none of the providers I met during my fieldwork mentioned realizing that potential as a primary motivation in their work.

Dr. Keller's path to correctional medicine was one such story. After a larger healthcare corporation bought the private family medicine practice he was a part of, he worked for a brief time in a nursing home before getting a job at the Philadelphia jails, following the advice of his wife who was a nurse there. Many providers who came through Graterford either on job interviews or for brief stints mentioned difficulties in setting up private practices outside of prison, especially if they had specialized and were interested in providing referral care, citing the growing reluctance of primary care providers to refer under insurance restrictions and guidelines. Other physicians like Dr. Khiabani, an older, Middle Eastern doctor who retired from a suburban surgical practice catering to a wealthy clientele, retired from their practices only to discover that they had not saved enough money or wanted to travel or do additional things in their retirement that required more savings, so working at Graterford became a bridge to retirement.

Dede, who came to Graterford right after nursing school, discussed the catch-22 of needing to get a job in order to gain experience, but how private practices would only

hire nurse practitioners who had experience. This is why she and many other midlevel providers started working at Graterford – they saw it as an opportunity to gain experience before getting another career elsewhere. Dede’s discussion of her ideal career and what she hoped to get out of practicing medicine were set in contrast to what she felt like she was able to experience at Graterford. She mentioned how, in nursing school, her favorite rotation was working in an HIV clinic. Her experience there inspired her to pursue a career in infectious disease that utilized a community-centered approach to healthcare. When I asked her what she liked about the rotation and what inspired her, she replied:

Dede: It was very... holistic. It wasn’t just the HIV and AIDS, it was... we provided care to them in every way, and we spent as much time as they needed with them. It wasn’t like, oh 15 minutes with this patient. Like, we can spend as much as an hour with that patient. And it was very community and family based, and they had groups for them ... on Wednesdays I think. And they had different activities for them and was... it was just, like a different kind of healthcare I never experienced. It wasn’t just, “Oh yeah you’re a patient and we take care of this.” Was like we take care of *you* and we take care of everyone that comes into contact with *you*, like your spouse, your wife, your children, like... how do we keep them free from HIV or if they are infected, how do we take care of all of you and meet your needs? It was just great. It was different. yeah, so...

Nick: And you’ve said before that you liked the idea that it was one, sort of contained disease. Even though you were dealing with a lot of opportunistic infections and other things that could stem from that, you were dealing with one disease process that helped you focus your energies.

Dede: Yeah, and clinically that was the advantage. I guess I’m thinking about like the other kind of... nursing that we could do.

Nick: Yeah, sure.

Dede: Right, clinically that was the advantage. Plus, it was just new and exciting to me. I didn’t learn that much about HIV in school, so it was like, “Wow they can actually have kids, and they don’t have to worry about, like...” It was just different. It was different, I guess.

Nick: Uh huh. And was the more holistic, community-centered approach to HIV care something that you expected to be happening in prison when you started there?

Dede: Um, no, not really. I didn't. [*laughs*] Yeah, I think it was more like the clinical, like... I just wanted, or thought that it would provide a good clinical experience.

Many providers offered this kind of reaction to their experiences working in the prison – that it would provide a good clinical experience, but that they didn't expect to be practicing the same kind of medicine that they saw themselves practicing either in school or that they had hoped to practice. When Lance, who initially took the job because Graterford was close to where he lived and “thought it might be interesting,” described how he thought he might also be able to “make a difference in an inmate's life,” I asked him if he felt like that was something he could or did accomplish. Surprisingly, his response did not involve the direct mention of healthcare services making an impact. He said, “Sometimes, yeah, you see a guy that appreciates talking to you or says that it's nice when you smile at him. And sometimes you can just offer them an encouraging word.”

I contend that it is processes like the collegial meeting and the inertia around institutional policies like those Dede eventually faced when trying to provide care in the RHU (see Chapter 4) that make it such that providers do not feel like it is possible to deliver care amidst the structural constraints they faced in the prison and their own participation in the continual framing of inmates as less deserving of care, which both mutually reinforced one another. Healthcare staff and administrators alike repeated phrases like “inmates think I can do more than I can do,” which overly relied on the constraints of privatized managed care and the security functions of the prison to justify the denial of care. This process was made all the more effortless by virtue of the fact that the same processes that guided managed care outside of prison were seen to operate within prison. Relying on the familiarity of managed care, despite the fact that it was operating in a much different structural context, made it easy for providers to see the failings of healthcare as unavoidable.

In addition to making the conditions of inmates' suffering invisible discourse of managed care and discouragement over inmates getting “free” healthcare that providers' tax dollars paid for, the circumstances of managed care were always referred to based on this familiarity, in comparison to the world outside prison. When Dede left her job at

Graterford and got a job at a private primary care practice in Philadelphia, working within the conditions of managed care in the prison even became a marketable skill. She mentioned how the person who interviewed her for the position had commented on how her experiences with collegial was “great practice” for helping her deal with insurance companies.

Similarly, some providers made comparisons to the larger medical context outside of prison when discussing how they had to practice defensively and order diagnostic tests balancing what they thought was necessary, what the patient wanted, and what they felt was cost effective. Tom, a white 46 year-old physician assistant who worked at Graterford the longest of any other midlevel provider, mentioned how he thought the setting of managed care within the prison encouraged a system of less wasteful practice that, rather than delaying or denying care as I show above, was more virtuous than the system of managed care outside of prison.

Nick: Do you have to practice more defensively and order more tests because of lawsuits or does the company’s system work to cut down on that while also giving the inmate what he needs?

Tom: I don’t want to say we order unnecessary tests, because it would be the same out here. You know, actually out here it would be more. You’re gonna order more tests, labs, and things on people that may be unnecessary. I think we’re pretty prudent in the prison. I mean, if...if someone has chronic pain in their back or something and they’ve had it, and they, you know, and you think arthritis, and, I mean... A lot of times what are you going to see that ... what’s the result going to do to change your treatment? [...]

So I would explain that to an inmate, like a muscle injury, “Well you’re gonna be in pain, and you don’t need the x-ray.” But I was a little more leery about people coming in off the street, complaining especially of neck pain. Because, you know, you get a lot of your lawsuits will come from... If you have a neck injury you have to be real careful. [...] So I don’t think I’ve done really anything that’s been overkill. Once in a while I order something and I kinda already know what the answer is. But... it’s piece of mind. Then the inmate... or the patient, will say, “Okay, I understand now.” Then for the rest of their lives they’ll leave you alone with that, but until you do that, they’re gonna be – any patient’s gonna keep – harping, harping, harping. And it would be the same for you and me going to the doctor. You complain long enough, you’re gonna get an x-ray, you know? They’ll say they want an MRI right off the bat. Well, that’s not the way it works anyway, but inmates don’t know that. They go right to the

extreme, or they want to go to a specialist. Well, you can't go to a specialist until you see one of our doctors here, you know. [...]

You're not gonna make everyone happy in prison. And you're not gonna make your patients happy here. Cause I've been out there, and I've had patients come in they want Percocet or they want Vicodin... you know? I mean that's here and there, in the prison and out. At least in prison you can say no and the inmate goes away because the guard is there, but... try doing it out on the street with someone who's been persistent asking you for a medication that you don't think they should be on, and then they come in again with pain... or an auto accident, and you know there's a lawsuit involved

Tom made consistent use of contrasting the prison to the outside world in order to justify or valorize the kinds of medicine he was able to practice in the prison, even remarking at how convenient it was to rely upon the security functions of the prison to back up his denial and have a patient removed.

In a similar vein, some healthcare providers who came through Graterford relied on the practices of managed care to evince a nostalgia for an imagined medicine that did not rely so heavily on diagnostic tests and advanced technology. Some mentioned being interested in helping underserved populations through organizations like Doctors Without Borders and how the exposure to “a variety of pathology you don't see in society” and the resort to this “more pure form” of medicine where healthcare providers relied on their intuition and senses to give them a sense of satisfaction and skills and that prove useful in “other resource poor settings.” While the prison itself was also technically resource-poor, such comments missed the fact that prison healthcare was only operating under conditions of scarcity through its own processes of cost containment. The pervasive context of managed care, and how those logics seeped in and out of the prison and relied on comparisons across different context also served to link the prison into these national and transnational healthcare markets.

¹ See Maskovsky (2000) for a historical and ethnographic approach to understanding managed care Medicaid programs in Pennsylvania. He describes how the privatization of state services shielded the contradictions in providing better healthcare services at lower costs, creating barriers to healthcare for Philadelphia's poor.

² See Fairman (2009) for a broader history of the emergence of nurse practitioners and their role in clinical care and HMOs.

³ In the period between 1980 and 1996, the U.S. prison population grew by over 200 percent. Unsurprisingly, these were mostly drug-related convictions, but convictions for all crimes increased. Convictions for non-drug related crime increased on average two-fold (Blumstein and Beck 1999).

⁴ See *West v. Atkins*, 487 US 42 [1988] in which the Supreme Court decided that a contract physician for a state facility was susceptible to Eighth Amendment litigation because the physician was acting “under color of state law.”

⁵ For clarity and reiteration, she is referencing some of her father’s contracts, which were often for a few facilities in a city or state. The five-year contracts for healthcare services in Pennsylvania’s state prisons were often over \$200 million, which coincidentally amounts to about \$2 - \$3 per inmate per day, compared to approximately \$27 for the U.S. population, although this is a somewhat fraught comparison due to the shared costs of private prison healthcare companies and the state, as well as offsets in government subsidy funding and discounted pharmaceuticals.

⁶ By “over refer,” she meant that the company could keep costs down as long as providers did not request too many specialist consultations.

⁷ See (Hornblum 1998).

⁸ A hydrocele is a sac of serous fluid around the testicle.

⁹ The “global period” is the amount of time for which post-procedural care is included in a billing package, meaning in this case that the delay in post-operative care would result in Wexford being charged an additional cost.

Chapter 3 – Caged and Invisible: Masculinity and the Loss of Care

I am a man of substance, of flesh and bone, fiber and liquids – and I might even be said to possess a mind. I am invisible, understand, simply because people refuse to see me. Like the bodiless heads you see sometimes in circus sideshows, it is as though I have been surrounded by mirrors of hard, distorting glass. When they approach me they see only my surroundings, themselves, or figments of their imagination – indeed, everything and anything except me.

– Ralph Ellison, *Invisible Man*

“That’s when they took me.”

During my second conversation with Troy Hughes, a 24-year-old father of two serving a four-year sentence on his first conviction, he described the night of his arrest in a dramatic scene of violence and family disruption. Before we got to that point, Troy laid a complicated foundation in which he detailed the tactics used by the police to pit members of his majority black community against each other and the complicated relationship he had with other members of his family. He claimed the police and the district attorney tried to get people to testify against their neighbors to get a conviction and provided no protection either from those seeking retaliation for the testimony or others who committed crimes against each other in his neighborhood. This partial, strategic investment the police had in his neighborhood had direct relevance to Troy’s case, in which he was named as a suspect for a string of related felony charges. Ten of his cousins had criminal records and shared his last name, setting the stage for him to either be misrecognized as one of them or be directly sold out by them. As Troy put it, “[The police] familiar with the last name Hughes. I got a clean name. And I was trying to keep it that way!” So when the police broke into his house to arrest him two weeks following an encounter where a police sergeant identified him by name at his cousin’s arraignment, Troy immediately suspected the problem: “So the first thing I’m saying to myself, right, is, ‘One of them done used my name because I got a clean name and they done got in some shit.’ I said, ‘Ok well we gonna figure this right on out when we get down to this

police district, because if you really think that you're gonna slide me beneath the bus on something, you got it wrong. You got it all the way wrong.”

At that point Troy still believed that his arrest was a simple mistake that could be easily clarified and did not yet know that it would be a minimum of four years before he would be able to return home.¹ As Troy sat across from me in the medical unit clinic office – a tall, sturdy guy in his tattered, yellow jumpsuit with a black “DOC” emblazoned on the back – he reflected on how long it had been as went on to emotionally recount the circumstances of his arrest and the challenge it posed to his role as a familial protector:

It's 7 o'clock in the morning, and I hear a loud shriek then BOOM! I came downstairs and they literally broke the door in. So my daughter, my daughter was two at the time. She came out screaming. She heard the shriek and the boom. So I'm like, “Yo, what's going on?” They slammed me right on my face, like we're talking right now [*gesturing to the three or so feet between us*]. He just walked up and slammed me [*punches his hand into his open fist, then bangs it onto the table beside us*].

So my daughter breaks away from my wife, and she wraps her arms around my neck. She won't let go. And he [the police officer] tears her from around my neck. [*pauses and closes his eyes tightly, taking a deep breath*] Right, so... I'm going off at this point. Now you done touched my kid and all that. So I'm going off. They... they beat the shit out of me. Yeah, they was going in on me, all in front of my daughter. That's when they took me...

At the conclusion of his trial, Troy was found guilty of burglary, assault, retaliation against a witness, and conspiracy – approximately half of the offenses he was originally charged with in connection to an old acquaintance the police saw him talk to at his cousin's arraignment. He got time served for two years of his sentence that he spent in the Philadelphia County Jail awaiting and undergoing his trial, and he was at Graterford to be medically cleared before going through the classification process to spend the remainder of his sentence at a different state prison.² Similar to his description of his arrest and his inability to protect and care for his daughter during such a harrowing moment, Troy described many aspects of his incarceration in terms of the difficulties it posed for him and his family: his inability to provide for them financially, to protect and

support them physically and emotionally, and to come out of prison healthy and with robust employment and educational opportunities. He referred to incarceration as degrading, turning him “from being a civilian to an animal” by taking away aspects of human behavior and culture that are often taken for granted like defecating in private, for example.

The way that Troy became reduced to the last name Hughes through his conviction, how he was betrayed in one way or another by his social and kinship networks, and how he was both removed from his parental role and had that role undermined during his traumatic arrest all contributed to an ongoing lack of recognition that continued through his incarceration at Graterford, including the medical care he received during his three-month stay there, which I describe in more detail below. Troy explained the experience of being on E block, where inmates arriving from county jails were isolated from the general population because they had not yet been classified and remained on lockdown 23 hours a day, at the mercy of the correctional officers who would take away, or “burn,” what were assumed to be privileges – like yard time and phone calls – over minor infractions:

This is peoples’ lives and all that. We already minimized. Our freedom has already been taken away. For either short or long, it’s been taken away. You want to maximize on it because somebody called you a name, so you burn us for yard. We only get an hour out of it! You burn us from yard, you burned us from talking to our families, you burned us from actually buying something that endorses the jail – the commissary. You burned us for that. Like, that don’t make sense! And you expect everybody to act civilized. They starving. They haven’t talked to their people in damn near a month. You want people to act civilized?

Troy said that given these experiences, the process of incarceration seemed illogical to him; the prison bore no resemblance to an institution that was supposed to “correct” or “rehabilitate.” He expressed this contradiction and the sense of degradation he was feeling through the cultural idiom and trope of masculinity, contrasting manhood with the animality he was made to experience:

They treat you like animals in here. Then want you to go back out and act like a civilian; I don't get it. You treat me like dog crap and you want me to go back out and act like I wasn't treated like dog crap, but no, you act like I became a citizen. That don't make sense! That's backwards. There's no, like, boot camp? I'd rather gone to boot camp. At boot camp they turn you into a man. You do this, you get this – it evens out. You an asshole? We'll treat you like one. You be cool, we treat you as such.

“Firm, fair, and consistent” was the oft-repeated logic derived straight from training manuals that guided many staff members’ articulations of how they performed (or were told to perform) their duties given the logistical and interpersonal challenges of working in a prison. At least from Troy’s perspective, the last two components of this logic seemed to be non-existent. Fairness, Troy reasoned, would mean to be recognized and treated as a man, even if a flawed man. It did not matter to him whether the treatment was unkind, as evidenced by his willingness to consider boot camp as an alternative despite its similar militaristic structure. Consistency, furthermore, did not require adherence to a protocol or a universal response, but a consistent use of logic in response to *individual*, human needs and actions. As such, Troy desired treatment that cast him less as an object or an animal and prepared him more for civilian life, appreciating his potential as a citizen, a father, and a man.

Masculinity has been tied to incarceration since the beginning of its widespread use in the United States in the early 19th century. Incarceration’s objectives were to deprive convicted men of their masculinity by untethering them from their social and kinship networks and to criminalize non-normative forms of masculine patriarchy and sexuality (Kann 2005). The conditions of citizenship and patriarchal family status defined manhood. Benjamin Rush, a Philadelphia physician and proponent of “Pennsylvania system” of solitary confinement and reflection as a form of rehabilitation, felt as though this form of punishment through emasculation would serve as a greater deterrent to crime than public spectacles of corporal punishment and could serve as the basis for a restoration of civic masculinity.³ This historical motive differed for black men, however, because they were seen to inherently lack the ability to be men culturally defined as such, and their criminality was seen to derive from this intrinsic lack of humanity and

citizenship. Whereas white inmates were made to lose their sense of manhood upon incarceration in the service of rehabilitation, black inmates were assumed never to have had manhood in the first place, and incarceration served as a means of control and management instead of rehabilitation (Davis 2001; Kann 2001). Troy's description demonstrates both the persistence of the links between incarceration and masculinity through the connections he creates between manhood, patriarchy, and citizenship as well as the persistence of elements of the lack of human regard with respect to black masculinity in his distinctions between inmate-animal and civilian-man.

Thus, in addition to – or because of – the loss of Troy's physical presence from his household and community, he suffered the loss of individuality as well as a sense of place, role, and identity during his incarceration. These losses were comprehended as the loss of masculinity and experienced through the desire and struggle for masculinity's recuperation. For Troy, recuperation meant trying to enroll in vocational and educational programs once he made it to his "home jail" (though he recognized that these were largely to keep himself occupied and make him look better to the parole board and would do little to improve his job prospects after incarceration). Troy spoke most often about simply keeping his head down, avoiding most other inmates in order to "wait out" his sentence and pursue therapy after his release. His desire for therapy stemmed from both witnessing the physical and mental effects of incarceration in others as well as experiencing them in himself:

When I get out of here, I'm gonna get therapy. Exactly what I'm gonna do. Because I grew angry from being here. I was never an angry person. This made me enraged with people. I don't trust people. If you told me something, I'll ask you a thousand times because I feel as though you're gonna lie to me. It just... see when I first met you, like the tape recorder and all that, I was... I was sketchy. This place make you, like, leery of people. It make you very, very leery of people, cause people hop on people's cases.⁴ Physically a lot of guys ain't gonna say it gets to 'em. I know it does, because it gets to me! And mentally, you're mentally depressed. You don't want to face it, but that's why a lot of people eat in here and get big. The constant anger, all that. Nobody supposed to be locked in a room 23 hours a day and get burned, probably burned from that one hour [outside the cell], for days on end. Like I say, you're gonna go crazy. But when I get out in the street, I'm definitely going to see me a therapist or a shrink or something.

Definitely, because if you not - like I was telling my cellie, I said, “Man, you better get therapy. I’m telling you.” “Aw, man, I don’t need therapy.” I’m like, “Listen, this place turns you from being a civilian to an animal. It turn you because you starved, you cold, you mentally and physically exhausted.” It’s a weight on everybody. It’s a weight.

Men lost many things during incarceration. Freedom, forms of familial and social support, trust, control, privacy, and citizenship are just a few examples that come out in the brief part of Troy’s narrative presented here. In this chapter I focus on how this loss was interpreted within the hermeneutic of masculinity (or, more accurately, emasculation) when inmates were placed under the care of the state. While the historical links between the loss of masculinity and incarceration have clearly persisted, any mechanisms for rehabilitation, especially through care, are overtaken by the gendering functions that prisons perform. Many scholars have demonstrated the ways that prisons and other carceral settings reflect and concentrate gender/sex structures and reify societal gender roles through disciplining the labor and recreation that inmates perform, perpetuating violence and criminality, regulating inmate-inmate and inmate-staff sexual contact, and segregating inmates based on gender and sexual orientation (see for example Davis 2003; Sabo et al. 2001; Stanley and Smith 2011; Sykes 1958). These systems of governance “trap” inmates in what Joe Sim has called, paraphrasing Max Weber with an unfortunately literal irony, “an iron cage of masculinity”(1994:105).

Rather than conceiving of masculinity as the raw material constructing this “iron cage” and how masculinity reproduces itself, I alter the frame of reference to include the negative space created by the metaphorical cage of masculinity that surrounded incarcerated men. What forms of suffering and care were lost, unrecognized, or uncaptured by prevailing notions of masculinity that were structurally reinforced by the prison and its healthcare providers? How did masculinity as a cultural construct pass through the cages that confined men’s bodies (as well as the bodies themselves) to not only materialize and reinforce hegemonic masculine subjectivities,⁵ but also to open up a space for redefining the possibilities for masculinity and care in the face of structural vulnerability? Assuming this point of view allows me to examine the complexity and contradictions that were involved both in the loss and reconfiguration of masculine

identity that accompanied wardship and in healthcare providers' ascription of gendered stereotypes onto inmate illness. I therefore take a view of the institution as one that was invested in defining and reproducing hegemonic masculinity (e.g. in making Troy angry, suspicious, and fiercely independent) even as some of its actions were perceived by inmates as emasculating, driving inmates at times to imagine alternate forms of masculinity tied to the acceptance or refusal of care (e.g. Troy's desired pursuit of therapy outside prison despite its stigma). I demonstrate how these taken-for-granted gender constructs appeared in the prison clinic and their implications for the provision of prison care that can must effectively respond to the types of suffering it structurally reproduces.

The figure of the male inmate as hyper-masculine, hyper-muscular, and hyper-dominant is ubiquitous in popular portrayals of prisons. Such figures contribute to commonsense, uncritical understandings of criminal convicts as aggressive and sociopathic in ways that are also tied up in persistent racializing tropes of embodied black criminality and the resultant desire to "tame" black bodies (see for example Collins 2004; Ferber 2007; Jackson 2006; see also Fanon 1967). I juxtapose this figure of masculinity with that of the sick, vulnerable, and infirm men who circulate through the prison's medical unit in order to contemplate its durability in the context of prison healthcare and the gendering functions of prisons more broadly. I understand this hypermasculine figure – as an imagined and fetishized object – both in inmates' reactions to the dehumanizing aspects of illness and incarceration and in providers' constructions of a generic, depersonalized patient. Through these considerations, I explore how raced and gendered perceptions of inmates as aggressive and overly sexual – and at the same time in need of care – contribute to the management of their bodies, creating categories of masculine inmates who are at a loss not only for masculine identity but also at a loss for care.

One can generally think of healthcare as something "gained" rather than lost during incarceration, especially for many who had inconsistent access to healthcare in their communities. However, the way masculinity was refracted through the prison cast men who were in need of care as oxymorons. Gentle, cooperative patients were seen as manipulative and deviant, and aggressive, demanding patients who met the prison's

expectations of masculinity were written off, labeled problematic, and/or punished. This created an impossible standard to which an inmate could hope to adhere in order to present himself in accordance with a certain gendered expectation of inmate-patient behavior. In this way men were lost as the object of care and were instead viewed as markers of masculinity and criminality who were impervious to pain and emotion and with whom developing an intimate, caring relationship was not only unnecessary but unprofessional. The incorporation of inmates into prison healthcare then took place on the basis of a biologically reductionistic understanding of medical need that squared with gendered expectations of the masculine illness experience. Evoking Ralph Ellison's description of invisibility and optical illusion in the epigraph, prison healthcare providers saw racial, criminal, and biological subjects rather than individuals in need of care – inmates, not patients.

This simultaneous incorporation of masculinity into the provision of care and the use of masculinity as a rationale against care deepens the connections between care and punishment that define healthcare in the prison and the kinds of constraint that are placed around the demonstration of medical need. Thinking about how the fear and rejection of black masculinity is often confused for care and love, bell hooks writes:

Black males in the culture of imperialist, white-supremacist, capitalist patriarchy are feared but they are not loved. Of course part of that brainwashing that takes place in a culture of domination is the confusion of the two. Thriving on sadomasochist bonds, cultures of domination make desire for that which is despised take on the appearance of care, of love. If black males were loved they could hope for more than a life locked down, caged, confined; they could imagine themselves beyond containment (2004:ix).

In a similar way, I consider how the gendering environment of the prison cares for male inmates, even as care takes the form of isolating, subordinating, and objectifying them.

In this chapter I primarily tack back and forth between Troy and Eddie, who was 64 years old and a father of three serving a life sentence. The discussion of these two men, who differed in age and sentence length, as the undercurrent of this chapter allows me establish some common ground between two often-opposed generational groups:

“young bulls” and “old heads.” These two groups were often perceived to have different levels of maturity, to react to incarceration differently, and to engage with healthcare services differently. Taking both of their experiences together frames some of the commonalities with how black men became the object of the prison’s clinical gaze, how the constructions of a masculine illness experiences left men at a loss for care, and how loss was a central organizing feature of the incarcerated illness experience.

Fraternization and the Legal Intimacies of Care

As with other dynamics of prison life, gender and sexuality were also circumscribed by legal doctrine. In this case the law simultaneously reproduced inmates’ vulnerability and reified conceptions of male inmate aggression and hypersexuality, encouraging distanced care. Based on the notion that, in some circumstances, sex between inmates can be coercive and bartered in inmates’ underground economies,⁶ consensual sex between inmates is prohibited and can be prosecuted as a felony.⁷ Sexual relations between inmates and staff are likewise prohibited; the intrinsic power dynamic between the two coupled with the state’s legal ownership of inmates discussed in Chapter 1 precludes an inmate’s freely expressed consent. Staff-inmate relationships also pose a threat to the security of the institution, creating situations where staff could smuggle contraband or collude in an escape attempt. The restrictions surrounding inmate sexual encounters and how they are endowed with power, value, and violence led to the passage of the Prison Rape Elimination Act (PREA) in 2003, implementing further legislation attempting to identify and control sexual assault in prison. Additionally, Supreme Court decisions like *Farmer v. Brennan*⁸ have reinforced the prison’s process of gendering inmates based on genitalia and segregating them based on that gender in ways that assume both heterosexual desire and the tight coupling of gender and sexuality. While all of these legal principles provide important protections for inmates,⁹ they also sometimes enact forms of violence and discrimination in the process (see for example Dolovich 2011; Robinson 2011). In the realm of healthcare, PREA mobilized the intrinsic order of the law and the power that it held in the prison to reinforce ideas about gendered behavior and the features of interpersonal relationships there. These constructs imputed a hetero/sexual and coercive dynamic onto all forms of care in the prison and instilled a

priori limitations on inmate-provider relationships, where social relations and compassionate care could be linked to these proscriptions on sexual contact and therefore seen as inappropriate or dangerous.¹⁰

The legal and professional stipulations around inmate-patient contact at Graterford were discussed informally using the language of fraternization. Fraternization was institutionally prohibited and defined in terms of a private relationship between staff and inmates that involved some elements of exchange and reciprocation – giving gifts or money that might compromise security.¹¹ Staff members almost always referred colloquially to fraternization having a sexual component, however, and there was frequent talk of staff members being fired and “walked out” of the prison for relationships or inappropriate contact with inmates. During my fieldwork, one female member of the medical staff at Graterford was fired for writing letters to an inmate and depositing money in his commissary account, which invited much talk and speculation about why a staff member would “throw their life away for the attention of an inmate,” causing Henry to remark one day how it “must take a supremely lonely kind of woman who can’t get a man to seek the affection of a criminal.” As a consequence of the legal restrictions around inmate contact and the discourse around fraternization, interpersonal connections between staff and inmates were seen as taboo – always already imbued with the logic that sexuality and licentiousness were the only motivating factors that could lead one to transgress those boundaries in order to relate personally to inmates.

PREA required all (both contractor and state) employees and volunteers working in the prison to undergo a mandatory training session.¹² These training sessions outlined the necessity of the legislation and instructed staff on how to best recognize and prevent sexual assaults. As such, the training session that I attended with the healthcare providers served as fertile ground for understanding the pedagogic reproduction of inmate masculinity in this legal doctrine and how clinical relationships could be built around such a construct. The training took place in the prison’s administrative wing, a newer addition to the prison separated from the main corridor by a heavy metal door painted royal blue in contrast to the other muted, neutral tones throughout the rest of the prison. I was buzzed through the door and entered a slightly more modern building with bright

fluorescent lights and mint green linoleum. We sat through an hour-long presentation in a second-floor conference room that had windows along one side looking out onto the parking lot and aerial photos of the prison along the opposite wall. Approximately 30 people were in attendance; about three-quarters of the crowd was healthcare staff, and one-quarter was correctional staff.

A young black woman who was not a Graterford employee gave the presentation, reading off a piece of paper while she scrolled through powerpoint slides projected at the front of the room. While she seemed prepared for the presentation, she also came across as inexperienced and a bit nervous in relying on her printed notes. After giving the legal background and context for PREA, she reviewed the definitions of consent, sexual contact, and sexual orientation. “Transgender” and “gender-nonconforming” were included as categories in the sexual orientation slide, which the presenter explained: “They determine who is going to be attracted to that.” The designation indicated both a lack of precision and nuance around the notion of gender given the strict binary segregation that the prison perpetuates as well as a certain passivity of someone who orients differently toward gender – that they could only be the object of a sexual orientation and not have a sexual orientation themselves.

Later in her presentation, the woman gave instructions for how to identify the perpetrators and victims of inmate-on-inmate sexual assault. She flashed a slide with white text on a crimson background that listed bullet points of what she was reading: “Aggressors often identify as straight. They’re street smart, often gang members. They feel at home in prison. They’re often black, large, and dominant, usually convicted of more violent crimes. [Breaking from her script] We call him a ‘booty bandit.’” She changed slides to a white background and blue text: “Victims are smaller, often – but not always! – white, and not as street wise. Sometimes they present as feminine, effeminate. They’re withdrawn.” She continued with other behaviors to recognize that would indicate potential for a sexually abusive relationship between inmates:

A big red flag is *concern* [her emphasis] over another inmate. For example, asking you, “Why’d he go to the hole?” or “I heard he’s out at the hospital. How’s he doing?” These are the signs you have to look for. And you know, snitches get

stitches, so they not gonna say anything. You gotta ask those questions. Everything has to be reported. If not, there's threat of termination. You've gotta do your due diligence!

The next topic was staff “sexual harassment” (as opposed to “sexual assault” in the former segment). The presenter described how “being in the custody of the state” led to an imbalance of power, so there was “no such thing as consensual interactions between staff and inmates.” Part of the staff behavior she outlined as constituting sexual harassment included “demeaning references to gender, body, and clothing.” One person in the audience asked, “Can we say he’s a booty bandit?” The presenter chuckled to herself and replied, “Not within his earshot you can’t!” A few additional questions from the audience followed about what exactly constituted a demeaning reference to an inmate’s body (could one, for example, comment on an inmate’s weight or muscle mass?) and how healthcare providers were expected to do their jobs if parts of the physical exam could be misconstrued as sexual contact or harassment. The woman presenting shifted to a more informal tone, visibly flustered by her inability to give clear, definitive answers to these hypotheticals due in part to the lack of nuance afforded in the law.¹³ “Look,” she said, “You just have to be professional. Don’t be doing nothing you not supposed to be doing! Firm, fair, and consistent.” She then pivoted to warn staff about inmates’ ability to gather information and turn reasonable and professional staff behavior into a cause for concern: “Don’t give out personal information, don’t have personal conversations within earshot of inmates. They ear hustle, they do all kind of things... so just be careful.”

The imputation of heteronormative identities onto already racialized depictions of the victims and perpetrators of inmate sexual assault (black perpetrators identifying as straight and white victims presenting in feminine ways) reviewed in the training session established a contradiction for inmates’ masculinities. Building on the historical configurations of race and masculinity vis-à-vis the prison mentioned above as well as the legal doctrine establishing the state’s ownership of inmates, PREA constructed inmates as both vulnerable and predatory. Black men were equated with aggression, with some men seen to occasionally relish in criminal sexual behavior to the point of

becoming sexual “bandits.” In contrast, white men – though they were too few in number to comprise all victims of sexual assault – were seen as more easily affected by the emasculating processes of incarceration and took on submissive and feminine roles. Furthermore, all inmates were put in a position of vulnerability with respect to their inability to consent; yet, they were also keen manipulators who could “get in your ear” and turn personal information or interpersonal contact into fodder for abuse claims or lure staff into relationships and then fall back on the legal protection around consent. In these examples, raced and gendered forms of sexuality in the prison came to include anything and everything except sex qua intimacy, which narrowed the spaces in which any form of intimacy could operate, including intimate forms of care,¹⁴ ultimately reinforcing the solitude and isolation that Troy described.

Inmates refuted the idea that sexual gratification or a predatory instinct drove them to pressure staff into manipulative relationships and take advantage of staff’s relative authority. Many inmates saw relationships with staff as fraught from the outset, and thus any possibility of sexualization carried with it enormous repercussions. In contrast to the descriptions of providers and other staff “throwing away their lives” for the affection of inmates mentioned above, from the inmates’ perspectives, it was they rather than staff who had the most to lose in such an attempt. Eddie explained:

It’s nothing to throw away everything... that you worked for trying to get out of the institution, just to touch her. You gonna throw everything to the wind and go to the hole and everything because you can’t stand how attractive and beautiful she is that you can’t keep your hands off her? [...] You know, she’s so gorgeous and appealing and desirable, can’t a man... he gonna throw everything that he worked for. He done went to school, he done educated himself, he did this and that, but he’s gonna say, “Aw to hell with all that I got to touch her!”

The logics confounding and extrapolating PREA ensured that everyday social interactions among all individuals that involved care, concern, and compassion were seen as threatening to the institution. The charge presented in the training session that concern for another inmate’s wellbeing was suggestive of sexual dominance and coercion is a particularly salient example. I spent almost every afternoon in the dispensary when the

inmates with insulin-dependent diabetes would line up for their injections. The inmates would frequently use the opportunity of regular contact with the nurse to make casual conversation and ask about any friends they had who were hospitalized or back in the prison's infirmary. To be sure, genuine concern for fellow inmates motivated these inquiries. Making these casual interrogations functioned as a mechanism to triangulate different information that was passed on through the prison rumor mill and to make sure their friends did not fall through the cracks of the prison bureaucracy, tucked away and forgotten about. As a form of information gathering, nurses frequently found this behavior strange and suspicious, even if ultimately understandable under the logic of concern. One of the more tenured nurses rationalized that outside of romantic relationships, the only reason inmates would care about each other is if they were lifers and had established longstanding friendships, consistent with the idea that older inmates serving life were less manipulative and their intentions were less complicated and more transparent: "You know they shouldn't ask, but I like to think it's just them worrying about their buddy. Most of 'em are old heads anyway."

The same rationales that assumed inmate relationships to involve deviousness and manipulation combined with staff concerns about PREA-based litigation to limit staff concern in the face of inmate suffering. At the end of my fieldwork, I received a letter from Roger, whom I introduced in Chapter 1 as having a delayed diagnosis of his lymphoma. In the letter, Roger updated me on his health status and described an episode where a bout of pneumonia resulted in hospitalization for a collapsed lung. Because he knew of my interest in his wrongful death lawsuit, he included a copy of a letter he had written to his attorney, in which he laid out the series of events: "On [date redacted] I was standing damp on the tier for over 40 minutes, when I went to my Section Officer, at approximately 1450 hours, and explained to him that I have pneumonia and asked if he could open my cell door, that I may be able to get in to get dress and not have my pneumonia condition get worse, since he slammed my door shut just after 2 p.m." The officers on his block told Roger to "stop whining" and refused to take him to the medical unit when he was short of breath.

The officers accused him of threatening them with a PREA lawsuit after receiving, quoting from Roger's letter, "the false information that I had filed a PREA complaint against their fellow 2-10 p.m. shift officer and had him removed from the block." The officers had conflated a complaint Roger had filed against a female officer for asking him to share food that he received in his meal bag that an administrator converted into a PREA complaint. Roger reiterated the rules around fraternization as part of his explanation for why he filed the complaint: "The rules is, I'm not supposed to give anything to you, and you not supposed to give anything to me." The officers charged Roger with four misconducts, handcuffed him, and placed him in the RHU. At his misconduct hearing, his request to review video from the surveillance cameras was denied,¹⁵ and he was found guilty, tarnishing his 15-year misconduct-free record. He continued to be confined in the RHU, lost his employment with no hope of regaining his \$0.43/hour earning potential, lost the Z Code (single cell status) he had for 23 years, and lost the ability to file for a commutation hearing regarding his original sentence.

Roger's pneumonia worsened in the RHU, where it was much more difficult to seek medical attention and warrant the necessary placement of restraints and use of officer escorts to see medical staff. Roger wrote:

I did not know what was actually going on, but I tried to explain to a male and female white shirt [lieutenant] that something was going on. [...] However, I couldn't talk, couldn't form words, and couldn't write. My cries for help went unanswered. I began passing out while standing up at the toilet for hours. I repeatedly hit my head on the floor as I had seizures at the cell door and remained on the floor in the same condition for a day or two without any assistance from staff.

After his lung collapsed, Roger became delirious and stopped responding to officers and coming out for meals, which caught their attention, and he was finally restrained and transported to the dispensary to receive medical attention. There, "the only thing I could do was point to my left lung area and say, 'Can't breathe. Need water. Need air' as the restraints were placed tighter on my left lung area." Subsequently, Roger claimed that staff performed unnecessary, invasive procedures (the placement of a

urinary catheter and a cavity search) because they assumed he was overdosing from heroin¹⁶ - procedures that caused some further physical damage and were conducted against his will while he was restrained. When the staff discovered that his left lung had collapsed and he had not overdosed on heroin, they attempted to have Roger consent to the procedures retroactively, constituting an attempt on the part of the medical staff to also avoid future PREA allegations, completely independent of the allegations tying Roger to PREA complaints on the cellblock.

To further demonstrate how PREA regulations affected providers' orientations to care delivery, after the training session some of the providers commented about how the PREA regulations limited their ability to perform thorough exams or even have sociable interactions with inmates. Claire mentioned that she had a hard enough time as a woman when she would become amicable with inmates: "I like to keep it professional, but heaven forbid I give him a fist bump! The whole prison will be talking!" Lance mentioned that if sexual contact were so loosely defined and consent were impossible, there would be a surge in lawsuits based on what an inmate might perceive as inappropriate physical contact. "If I can't get consent, there goes the DRE [digital rectal exam]! He'll be screaming, 'Rape!' And I'm powerless if I can't say he consented." While Lance's comment appeared to be slightly exaggerated – consent for sexual contact and for the performance of a medical exam, while both problematic in their own respects, were different, and medical exams like the DRE were legally protected by written consent – his and Claire's real concerns rested on the apparent danger of applying the legal construction of inmate masculinity to clinical encounters, in their apprehension in resolving how inmates could be both vulnerable and predatory – in need of care, but also able to utilize the law in a way that was seen as manipulative when placed in a position of vulnerability. Claire's and Lance's comments also demonstrated how these concerns and the now even more pervasive threat of litigation could reinforce distance and detachment in the clinic to avoid both potentially taking advantage of inmates and being taken advantage of themselves. Thus, the legal inscription of gender and sexuality formed interpersonal boundaries around care in the prison through its ability to seep into everyday encounters and instill suspicion and mistrust.¹⁷

If we return to Roger's case, we see that the block officers initially denied him care, and then medical staff subjected him to potentially unnecessary invasive procedures against his will and sought legal protection after the fact, all under the convoluted extensions of the law that limited concern and care on the basis of sexual misconduct. When I asked Roger why he thought the officers on the block refused to take him to the dispensary and charged him with misconducts, and then why the officers in the RHU were delayed in taking him to the dispensary after his lung collapsed, he replied, "I think they was scared." I followed up, "What do you think they were scared of?" "In jail, you don't see nothing, you don't hear nothing, you don't get involved with nothing that doesn't have nothing to do with you. It always turn out with PREA and the grievances, stuff like that, people don't wanna get involved and then I'm the only one that got punished." For Roger these limitations set into motion a chain of events that further limited care and paradoxically annulled his consent at every step. In the letter to his attorney, Roger wrote:

Neither the urine taken by force, nor the body cavity search had anything to do with my collapsed left lung from the untreated pneumonia and/or my being treated for the actual life threatening medical condition I was [...] treated for. Therefore, these two procedures constitute rape, the use of excessive force, and have caused actual physical injuries that still have not been corrected and fully discovered.

Ironically, an incident born out of a group of officers' anxieties about a PREA complaint resulted in the kind of mismanagement that led to Roger actively seeking representation in a PREA-related lawsuit against medical staff. What comes out of Roger's story is that their lack of regard for him, their use of force, and willingness to conduct unnecessary invasive procedures is what, in fact, generated Roger's understanding their treatment of him as rape rather than the inherent invasiveness of the procedure being misunderstood as bodily violation, as was Lance's gloss. Similar to his framing the misdiagnosis of his lymphoma in Chapter 1 as murder around the legal interpretations that construct notions of intent in "deliberate indifference," Roger's familiarity with legal understandings of transgressing bodily boundaries shaped his

experience or poor care and created a language with which he could articulate it. In this case systems put in place that were meant to protect him were imputed with ideas about sexual conduct and inmate manipulation and were instead leveraged so staff members could protect themselves, ultimately creating the very conditions they were intended to counteract. In a follow-up meeting with him after he sent the letter, Roger highlighted how counterintuitive the situation was and the lack of protection PREA afforded: “When PREA came in to find out how the program is going, I said, ‘It’s not going! The PREA complaint that they turned my grievance into, I got retaliated against! And then everybody in the jail knew about it!’”

Melancholic Masculinity and the Labor of Care

During my fieldwork, Pennsylvania was building a new, \$400 million prison directly behind Graterford as its eventual replacement. The state-of-the-art facility would boast a series of smaller units with short blocks that radiated from a central command bubble to replace the long corridors of cell blocks at Graterford that housed as many as 800 inmates each. This new design would also allow for a separately contained campus comprised of units that would house female inmates, a rapidly growing portion of the inmate population in Pennsylvania,¹⁸ who were in transit from other state institutions. The possibility of admitting women into the state’s custody at the institution generated a lot of discussion among providers about the comparative aspects of treating male and female populations and especially raised concerns about mixed-gender interactions between staff and inmates. These conversations served to condense a host of issues about how gender functioned across power in individual encounters and reflected the gender structure of the prison more broadly. I would unpack these issues in interviews with inmates when discussing their experiences of wardship and providers when discussing their roles to get a better understanding of how gender came to mark the kinds of labor that prison staff performed and to cast inmates as the objects of that labor.

One afternoon in the dispensary, a black nurse named Jasmine was discussing the staffing considerations for the new prison with me, Henry, and another nurse named Mara. Jasmine had worked as a correctional officer before becoming a nurse and had worked for the state in total for almost two decades. Mara was younger, white, and had a

background as an army nurse before working in corrections. There was a rumor that the administration was attempting to ban male officers in the future women's unit, which Jasmine thought was counterintuitive and discriminatory since female officers currently worked at Graterford, a men's institution:

That kills me though that they say it's gonna be all female officers working over there and no males, but you got female officers working over here with the males, and we've seen our share of them walked out – I don't know how many of them, you can't count anymore – for messing around with the guys. But you looking out for the male officers! You making sure. You don't even want them coming over there because you know they gonna fuck some of these girls! You know! You know it's gonna happen, but you protecting the men! You not looking out for the women over here, but you protecting the men.

Because Jasmine was openly gay, she wondered how these restrictions would affect her, pointing out that any legal rationale for restricting mixed-gender interactions did not map onto the reality that sexual orientation was independent of gender. She said she wanted to ask her supervisor if they would also forbid her from working there because of her sexual orientation:

Jasmine: Are they gonna discriminate against me? They're discriminating against the males. They're saying only female officers can work over there. No male COs are going to work over there. How are they even going to get away with that? Because you're going to have to have higher-up management, and you have male *and* female lieutenants.

Mara: And you figure any incident.... You're gonna get a bunch of females to jump on that unit?

Henry: They'll do it until somebody files paperwork, and then it'll be a challenge in the courts, and you know... like everything. As a male I wouldn't want to work on a female housing unit alone, because... you're vulnerable. You really are.

Mara: I don't want to work on a female housing unit.

Henry: They could say anything against you. *Anything*. Just take the gynecologist. If he's in there alone and he doesn't have a nurse with him, she could say he did *anything* to her. Who's gonna dispute it?

Mara: But the thing is, how many times do we walk on the block for emergency call, and you see the guy walking out of the shower without his towel. You go down to the RHU when they're doing showers, they're in their towel being handcuffed walking.

Jasmine: Or they're in the shower, period. How many times have you walked in to give meds and they're right there in the shower? It's a man's world. They don't give a shit about the women, they're looking out for the man.

Mara: I still remember my interview. They asked me how I was going to handle working in an all-male institution. I was like, "I was in the military. I worked in a male-dominated profession, and I live in a male-dominated society." How's that for experience?

The providers' discussion highlights how the prison reflected the broader patriarchal social structures of a "man's world" and was construed as a male space through its ability to "look out for" men, both in protecting male staff from female inmates and not protecting female staff from male inmates. In this case the masculinity of the prison was elaborated in the form of an innate and recalcitrant male sexuality, rendered in the libido of the male officers, whose detrimental effects could only be controlled by limiting access to female inmates, and in the intrinsic, objectified sexuality of nude or partially nude male inmates. Henry also brought up the assumption that continued legal resolution would be necessary to balance the prison's maleness against the presence of female staff and inmates. Despite the inadequacies of the law resolving contradictions that gender and sexuality bring to interpersonal relations highlighted especially in the example of PREA above, his comment presumes that an iterative and reactive process of legal arbitration would eventually achieve a workable model for correctional care that could erase the complexities of gender for the prison.

The undercurrent in this discussion (and especially the question Mara received during her job interview at Graterford and the mention of legal arbitration) was how much work went into the maintenance of the prison as a homosocial, masculine space. Gender and sexuality threatened the masculine labor that staff members were meant to perform as custodians and caregivers of inmates and affected if and how inmates could be seen as recipients of that labor or, for that matter, be seen as masculine themselves. In

this way, patriarchal masculinity was entrenched in the prison's social relations and was set into relief by the changes it gave rise to across labor and power. The very idea that labor relations for staff, the veracity of sexual assault claims from vulnerable inmates, and contact with inmates altogether would be altered to maintain the maleness of the prison rather than questioning the assumptions and appropriateness of perpetuating these patriarchal dynamics demonstrates how fixed the masculine identity of the prison was. Additionally, the ways the prison was maintained as masculine illustrate the implications of this fixity for inmate care. Despite the safety and wellbeing of inmates being the purported rationale for managing gender interactions in the first place, this rationale was subsidiary to labor concerns and only functioned to further refract the imputation of dangerousness placed on inmates receiving care. Indeed, if the prison "looked out for" male officers by supporting their labor, it "looked away" from inmates in the process.

The boundaries that constrained the exercise of care in interpersonal relations as described in the previous sections were therefore also present in the gendering of prison labor. In this way, masculinities that reinforced male authority and dominance over women (and dominance over men who were emasculated by the experience of incarceration) could be enacted along vectors of power and labor, complicating the masculine subjectivities of inmates and confusing the labor of care in response to those subjectivities. The presence of female, transgender, and gender nonconforming bodies and the performance of caring and compassionate labor were out of place in the imaginary of the prison as a monolithic male space, which helped solidify and project patriarchal ideology (see Bird 1996; Sedgwick 1985). As a consequence of these projections, made visible and material in discussions like the one above, inmates were either treated as men in need of control or cast as emasculate or infantile objects of a form of care that was rendered structurally impossible by these rigid, patriarchal norms. Therefore, I examine how the maleness of the prison was contested and negotiated among those occupying different roles within it. I look first at the formation of inmate masculine identity as a result of incarceration and prison care and then relate that identity to being the object of care and custody that involves gendered forms of prison labor.

The maintenance of the prison as a male space continued to be reflected in providers' discussions comparing care for male and female inmate populations. Most providers expressed a dislike for gynecology and were pleased that they did not have to provide obstetric or gynecological care. For the most part, however, providers expressed an overall desire to care for male inmates over female inmates because male inmates were "more straightforwardly manipulative," and providers relied on misogynistic tropes about hormone swings and women's menstrual cycles (as opposed to aggression and anger) to rationalize female inmate manipulation and how they thought "caring for thousands of female inmates having PMS at the same time would be a nightmare." As Claire put it, "Female inmates are bitches. They'll play you for their own amusement. Men at least you can understand, it's more predictable. You can never tell what's going on with a woman." Thus, male inmates were seen as predictably aggressive, and their behavior could be reduced to self-interested motivations for (sexual) attention or gratification understood in the context of their confinement. The staff also attributed many of these behaviors to hormonal composition for male inmates, as I discuss below, but these connections were seen as a more inherent part of their biology that could possibly *be manipulated*, rather than a dynamic and unpredictable *source for manipulation*. For the most part, providers' comments indicated that the masculine environment, even its very homogeneity, allowed them to better understand forms of manipulation that they saw and intrinsically masculine.

In this context it was also easy for staff to lose sight of how inmates became sexually objectified as recipients of care. Complaints of inguinal hernias and urologic issues were unsurprisingly frequent in a male population, and priapism (a sustained and painful erection in the absence of sexual arousal that poses risk of necrosis) was a reasonably common symptom of men with sickle cell disease or who were taking antipsychotic or antidepressant medications. Providers would sometimes joke about how inmates might want to request female providers for those issues, how female practitioners could "take care of" erections, or how inmates should get their cellmate to "help them out." Additionally, some nurses and correctional officers in the infirmary bubble would watch men masturbate on the closed-circuit television screens that monitored the

psychiatric and medical observation cells and mock them when they were placed in their cells nude, with only a Kevlar blanket or “suicide smock.” In contradistinction to Jasmine and Mara’s comments about how men forced them to endure their nudity and were made to not have an opinion about their privacy, inmates mentioned how embarrassing and degrading this was. Despite for the most part being careful and considerate about if and how they undressed, especially in front of female officers, they felt like the inevitable lack of privacy in prison fueled their objectification and was frequently held against them in allegations that they wanted to expose themselves for sexual attention.

Thinking back to Troy, introduced at the beginning of this chapter, and how his senses of loss were articulated through the experience of being made to feel less like a man and less than human, we can begin to see how the loss of civic, patriarchal masculinity contributes to a feeling of emasculation through subordination in this male space. With the loss of power came the perceived loss of masculine authority, especially over women, even though he may not have even had this kind of authority in the first place. Despite Troy’s lamenting the fact that he could no longer provide for his family, he did not really imagine himself to have been a strong economic provider for his family per se, but to hold the potential to become one. In fact, his wife was the biggest contributor to the household income through her job as a CERT team officer in the Philadelphia jails, providing for her family with the very same labor whose implications and intentions Troy had questioned. Before he was incarcerated, Troy worked occasionally as a bouncer and was working toward applying to college to increase his earning potential – efforts that were subsidized by his wife’s salary. This dual process of emasculation had implications for how he saw himself through the eyes of correctional staff as sub-human, and his skepticism toward care. Because he already felt like they would do little for him, he echoed many other inmates’ stances on bringing issues to medical attention: “It’s more discipline than it’s actually helpin’ somebody in here. Ain’t nothing really much you can do about the healthcare. Plus a lot of guys just winging it, it-is-what-it-is mentality, you know? They’re not going to keep trying to change anything. You gotta think it’s real life threatenin’ for someone to, you know, go through all that.”

Eddie grew up in the 1950s and 60s with three sisters in a household run by his mother. He asserted that this strong female influence on his upbringing and being raised in Philadelphia contributed to his more progressive stance on gender and sexuality. He had a male cousin who was gay, and said that he and his children would always serve to educate their relatives from outside of the city both about homosexuality and the ability for women to work within and outside the household. He was incarcerated when he was 21 years old, but the kinds of caring labor that women in his life provided did not stop there. As I discuss more in Chapter 5, a female friend of Eddie's named Diana took the time to make the hour drive from Philadelphia at least once a month and helped organize events to raise funds to pay Eddie's legal fees. She described this work as "like doing time with [him]."

Diana's brother had also been incarcerated at Graterford and, after serving 18 years, died there of congestive heart failure while he was still in his forties. This, Diana said, was what motivated her to care for Eddie: "After my brother died, I said we're not gonna leave Eddie up there to die like my brother died. That was something that I took on personally. I felt as though since we, uh, not *failed* to get my brother out of jail, but since my brother passed... we just went on to Eddie, you know, and tried to help him, to see if we could get him outta there." Eddie's decline in health and Diana's brother's death motivated her to call to make sure he was receiving his medications and to make repeat visits. She had little faith in medical services and felt like she needed to make phone calls and constantly be requesting information, which she was usually granted because Eddie had signed a release of information and made her his power of attorney: "We have to keep callin' and making sure that they take him out to the hospital and making sure that they doin' things for him. If you never called up there, if you never, um, inquired about his conditions, we would never know!"

Her desire to care for and tend to the needs of Eddie and her brother even compelled her to buy the foods that were stocked in the vending machines for visitors to purchase, despite the lack of healthy and diabetic-friendly foods and the fact that both men had diabetes and both had partial amputations. Diana said that eating food "was what he liked," "so we mainly just make sure he eat whatever he wants to eat while we're

there, and I know it's hard, but it's one of the few things we could do about it!" In the larger scope of what drove her compassionate acts, making sure that they were happy and felt looked after was more important than making sure they adhered to a medically mandated diet, especially one that, as I mention again below, is not even followed in the prison's own food offerings. Reinforcing how gendered this work of care was, , one of Eddie's male friends, who was formerly incarcerated himself, Eddie described as "too busy with other things going on with the businesses he was trying to grow" to make the visits. Instead his involvement in Eddie's outside support network was limited to helping organize and promote fundraiser events in the community.

Women often continued to participate in the extended familial and medical care for men that took place after incarceration. Mothers, girlfriends, aunts, and sisters called the prison medical unit to make sure inmates were taking their medications and being seen by doctors, providing an important mechanism for accountability and documentation. Many inmates also described having female friends or relatives who worked in healthcare fields from whom they would solicit second opinions on lab values and information that providers conveyed to them in their clinic appointment. Some of these second opinions even played key roles in the ultimate diagnosis and treatment of inmates' illnesses, as was the case with Roger sharing the results of his blood cell count with his niece prior to his lymphoma diagnosis. Even outside the visitor's room, mostly women occupied the benches near the front gate where visitors would wait for admission into the visiting room. When men were involved in this kind of work, it often took the form of accruing capital to invest in legal funds and helping to organize community functions, rather than spending time with inmates or directly overseeing their care.¹⁹

In contrast, the kinds of care that inmates received at the hands of female correctional staff had the potential to disrupt the perceived maleness of the prison, and being placed in a position of subordination to them elicited feelings that ran counter to their experiences outside prison. In descriptions of the caring and custodial roles of prison staff, this work was described as "like taking care of a bunch of children," comparing the prison to day care or kindergarten. This idea was married to the notion that inmates were in need of maternal care, but that care was mitigated by inmate aggression, a sense that

inmates should take individual responsibility, or even by the recognition of truth in the logics underlying the limitations placed on interpersonal relations – that sexual attraction could transform the potential for care into something inappropriate. Officer Cook, a black, female correctional officer who had earned a permanent position in the medical unit after 15 years of employment at Graterford, explained her thought processes regarding the dangers of attraction and maternal care:

Nick: Being a female guard in a male facility, are there challenges with that?

CO Cook: I think in the beginning when you first start there are challenges. You come in, and you see a ton of men. And mental challenges! Some you find attractive, some you don't find attractive, and keeping the balance between... you see what I'm saying? Keeping that balance of not crossing that line and being inappropriate with anybody. That's what the challenge is, I think. I think. Sometimes I'm, I'm a mother to a lot of these guys. The females period. A lot of these guys never really had any nurturing from their mother, and we provide that just by listening, to a story you might not even want to hear.
[...]

Nick: And you mentioned before how being a maternal figure can sometimes be helpful?

CO Cook: And sometimes hurtful, because people become attached. I remember years ago when I first started, there was a guy... and I kinda felt sorry for this kid. I would talk to him, and he would read me his poems, and the next thing you know he started writing letters! You can't do that! You can't do that. I need my job. You can't write me letters. So then you have to take a step to try to start being mean to them and make 'em leave you alone. Sometimes that doesn't work! So it's... it's trying not to cross that line with these dudes.

Nick: What's been your perception how inmates respond or react to that maternal role?

CO Cook: Some of 'em appreciate it. Some of 'em do. Because again they didn't have that nurturing at home. So some of 'em do appreciate it. Some of 'em, they just need it. I just don't care. I just don't care, one way or the other. Some dudes are just so angry at themselves. They don't realize they angry at themselves.

Officer Cook explained how quickly and easily she saw a relationship built on concern and nurturing potentially becoming inappropriate, and again relied on the anger

and transgressive behavior of inmates to justify failures in interpersonal connections and nurturing care. Even if inmates desired or needed maternal care, it was clear that female officers were not socially or structurally in a position to provide it both because of the constructed interpersonal boundaries that have already been described, the fact that women outside of prison continued to perform caring labor that was not institutionally limited in the same way, as well as female guards' placement in a position of authority over men in the prison.

The transition that Officer Cook and other female officers had to undergo she described as relying on her "police tactics" when her "mother tactics aren't working," suggesting that she too drew a distinction between a more feminine, caring approach that had precise limitations in a carceral setting and the more masculine, militaristic behavior that was able to surmount those limitations. Thus, not only could gender be performative (Butler 1990), but masculinity could be disaggregated from gender in this context and be performed in a way that also bound together labor and power (Connell 1987) and maintained the masculinity of the prison as an institution.

Troy's explanation for some of the more emasculating functions of incarceration involved the presence of female officers, criticizing them despite having a wife who was an officer in the Philadelphia jails. He described the social boundaries around contact and conversation with them as laced with suspicions of misogynistic treatment and sexual objectification, and how they work the performed contributed to the counter-rehabilitative functions of the prison:

One thing I noticed in here, you come through these places, and how they're organized, and the way that they talk about how parole works, you come back worse than what you was. They make you worse than what you was. You can't be nice, you can't be settled, you can't be civilized. Especially with women! You can't be civilized with them. You say hi to them they look at you like you crazy! Like, you is a person. We are people here, right? I see you every day, so I'm just saying hello! You can't be civilized! [Female COs] say it's all about disrespect.... Naw, that's just a straight out lie. I seen a lot of inmates disrespect them. I seen a lot of 'em, but I actually seen like inmates actually have a conversation with them. Like, you talking about fraternizing. Like, no, we ain't screwin'! We not doing that. A conversation ain't hurt nobody.

Almost all of the inmates that I spoke to mentioned that having female officers in charge of them contributed to the most demeaning aspects of incarceration. Those who, like Eddie, had been incarcerated there since before the introduction of female officers in the late 1980s even cited it as “one of the worst things to happen to the institution.”²⁰ Sometimes what was perceived to be a loss of patriarchal control and the impetus to maintain homosociality that was ostensibly less complicated by sex and gender played a hand in inmates’ reluctance to cede authority to women. These structural beliefs tended to manifest in expressions of how female officers might be reacting to patriarchal social structures violently in a setting where they were given authority over men and could serve as extensions of the punitive and disciplinary arms of the prison. Eddie explained:

You got a woman hollerin’ at you. Up in your face, too! And you got to bite your tongue. She actin’ like she a man. See, a woman in charge of other men, she gotta go *farther* than the men go so she could show that she’s just as tough or just as disrespectful as a man. So she go overboard a lot of the times! It wasn’t long ago I was coming from the block and this woman, she’s about 5’5” and this guy’s about 6’2” and she’s up in his face. “Didn’t I tell you such and such?!” and stepped up on him! He had to lean back not to be towering over her. He put his hands up, “Whoa. That’s not what I said.” In real life he coulda [*snaps his fingers swiftly*]. He trying to go home, he knows the consequences and whatnot, so he checked himself. *She* didn’t check him. He checked himself! She’s no threat to him physically, but she’s up in his face like “If you don’t do this I’m gonna slap you!” That’s the kind of post she took. [...]

Here’s a woman, and the things that come out of her mouth never meant anything to anybody. She not educated so she couldn’t school nobody or educate nobody or anything. She got off the welfare lines or something like that and got this job now, and here she is, a woman that nobody ever listened to anything she ever had to say, and not only they never listened to it, it never had no validity to it, never meant anything. Her kids don’t even listen to her: “Oh mom you’re trippin’.” She tell them to come home 8 o’clock, they come home 2 o’clock in the morning. Her own children don’t even listen to her! But now when she walk in this door, four thousand men got to move on her order and do exactly what she say when she say it. Some can handle it some can’t. Some know they got [power], but they still just, and they still fair, and they still honest, and they still respectful even though they got that clout. But some, they see us it’s almost like they rubbing they fist together “Oh I got him now!” and God forbid you look like her ex-husband, or her baby daddy! [*laughs*] God forbid it’s that time of the month, you know what I’m saying? [*laughs*]. Now she really gonna take it out on you.

You in the hole, you don't even know how you got there. [*turns somber*] It's that bad. You in the hole... because she in a certain way.

Eddie's comments are exaggerated to the point of offering a caricature of preexisting stereotypes about black women in order to make his point about how he and others see women as not suited to being in charge of other men and how their punishments can be unpredictable. He draws on forms misogyny unexpected from someone with his background and attitude towards his female friends and family members, realizing and reacting to an expectation for masculinity in the prison and the threat posed by masculine labor not being performed by men. In fact, he used his personal history to justify his responses against female guards and quell accusations that they came from a place of pure misogyny. He would follow up comments like those above with a description of how he grew up "surrounded by women" and how he was "a lover of women."

However hyperbolic his description was, the overcompensation that he described as a "reaction to the lack of a woman's authority in society" was borne out in my observations. Women officers were often more aggressive and vocal in confrontations with inmates, and male officers were more laid back and only rarely relied on assuming an aggressive stance or posture to assert control. In the most egregious example that I saw of these performances of masculinity by female guards, an officer in the infirmary was opening up a Medical Observation Cell [MOC] in the unit so we could see a patient that had been beaten up in a fight. We were told that the inmate had been selling Tylenol with codeine, and once the officers began monitoring and limiting his trips to the medical unit, his supply ran out and one of his buyers beat him up.

The officer was a thin, short black woman who wore her shoulder-length hair loose instead of tightly pulled back as I had seen it with other female officers. She struck me as somewhat out of place in the way she carried herself. She interacted pleasantly with the other staff, but offered a resigned shrug when asked to open the cell door. My immediate impression of her was that she must have gotten a job in corrections for the most frequently cited reason, that the job was "easy pay," and not because she enjoyed it or found meaning in the work. As she walked up, she told me and the medical director

conducting rounds that the inmate had been throwing his food on the ground and smearing feces since being put in the cell the night prior. She approached the inmate who was lying on his side on the cold linoleum floor facing the wall, saw his tray of food sitting outside his cell untouched, and immediately began screaming at him. She used every available angle to debase him, linking mental illness, victimization, and sexuality to emasculation:

Fuck you. You got beat up on the block, and now you're trying to act like a big man. Fuck you. You're nothing but a fucking pussy! Oh you're gonna get written up for this, big boy! I hope you enjoy the time you spend in the fuckin' hole you fuckin' faggot. Is that what you like? You fuck them boys on the block? Fuckin' faggot. Ohh they gonna have fun with you on L [the RHU]. I hope they break your ribs and everything, you schizophrenic nut job. You sick, nutty fuck!

Initially, the inmate didn't respond at all, but eventually he started saying things to question her accusations and her handling of the situation like, "Oh, is that how you're gonna play this?" At one point he started yelling, "Fuck you," back to her, but couldn't keep up with how quickly she was throwing out insults. It got so hostile and distracting as they started repeating insults and screaming that the medical team moved on to see the next patient while the officer continued to yell at the man in the adjacent cell. After a few minutes we finished seeing the next patient and the officer joined us in the hallway, resuming a somewhat professional, unassuming affect. "Y'all didn't hear that. I apologize." The providers started laughing. "Hear what?" they said. "Exactly," she replied, smiling. They all continued to laugh until she broke it up: "No really, I just wanted to apologize. I guess that was outta line, but they think they run the place, and sometimes you just gotta show 'em what's what."

I suggest that the gender dynamics and antagonism involved in care and custody within the prison were primarily the byproduct of institutionalization that highlighted the absence of inmates' ability to exercise patriarchal authority. Inmates' lack of authority and power and the construction of the prison as masculine created an allure both for officers to perform masculine authority over inmates and for inmates to feel and process the loss of authority in their reactions towards the women who perform it. These sorts of

interactions served to demonstrate the kinds of violence enacted in the service of maintaining the prison as a masculine space, elucidated both in the officer's outburst and the conflict created for inmates who then feel like they have to balance their subordination and ultimate goal of release with the anger and frustration that they are made to feel as a result of that subordination. What is sort of ironic about this dynamic of loss of patriarchal authority and compensation is that patriarchal authority became fetishized through its enactment and its perceived loss, such that what was lost was felt and expressed more deeply than the authority itself. In other words, given the fact that women outside of prison were primary income earners, ran households, and generally supported and cared for men, the vacuum of male authority created for inmates made it seem like they lost more than they had to begin with, and this loss was projected onto the administration of institutional care and custody in the form of avoiding or delaying seeking care and in needing to balance "self control" with expressing one's vulnerability in order to be seen and heard, as in the example Eddie gave.

Understanding the complicated relationships male inmates had to care and control requires recognizing how the institution creates the loss and recuperation of these masculine identities, not just through dispositifs that discipline and shape masculine subjectivities (Foucault 1975), but also through the psychic experiences of men struggling with the contradictions in masculinity that incarceration entailed. In Freud's "Mourning and Melancholia," he describes melancholia as the ungrieved loss – typically of an object of affection – that involves internal work and incorporation. Incorporating aspects of what was lost into the ego and projecting them outward as facets of the self therefore becomes the way the lost object is processed (Freud 1989). Though Freud describes this condition as pathological and primarily with respect to the loss of people, various scholars have taken up this framework to understand gender through the loss of libidinal desire (Butler 1995), race through othering and assimilation (Cheng 2000), and drug addiction through displacement (Garcia 2010; see also Eng and Kazanjian 2003).

Melancholic identification with masculinity in this context serves to cement the loss of masculinity in the ego and prevent it from being felt as a loss. As Freud states, melancholia can "include all those situations of being slighted, neglected or disappointed,

which can import opposed feelings of love and hate into the relationship or reinforce an already existing ambivalence” (1989:588). Here, melancholia for masculinity galvanized around the labor of care and control and created ambivalent feelings about being the objects of those particular functions of the prison, but also served as the basis for formulating new masculinities, which I explore in Eddie’s case below. Inmates were, in this way, mourning a form of masculine authority that can be said to never have existed, but was brought into stark relief by the degrading and dehumanizing aspects of incarceration. Wetherell and Edley call this kind of reflexive self-evaluation and self-shaping work done in gender identity “imaginary positioning.” (1999:342). Inmates positioned themselves against an idea of masculinity that was only felt and experienced as the negative image of that idea, but had real implications for experiencing care and encountering the reality of subordination during incarceration. In the context of expressing pain, for example, which I revisit below, inmates felt the deep ambivalence of expressing pain and occupying a position of weakness or being assertive and occupying a position of aggression and control that could then be punished.

Importantly, the sentiments that inmates expressed against female officers almost never applied to the context of female healthcare providers except in cases where female nurses were described as strict and stern or else passive to correctional staff. Nurses, who were employed by the state and whose jobs thus contained longer tenures, were seen as more aligned with the correctional staff. Some nurses like Jasmine even had prior careers in corrections before becoming nurses. The correctional officer’s job was seen as masculine, militaristic labor that subordinated men and was ill suited for women who, when they occupied that job, emasculated men by placing them in a position of inferiority. Healthcare, on the other hand, was often considered at least to have the potential to be more nurturing if staff provided the core service of listening and taking an inmate’s complaint seriously. Healthcare providers served to restore health and vitality rather than take it away, and women could comfortably occupy that role without threatening an inmate-patient’s masculinity. In fact, gender was not as frequently seen as the characteristic that defined the medical staff’s treatment of inmates as it was for officers. Instead, it was a provider’s inability to listen or convey empathy and their

placing inmates in a position to have to argue for medical care that determined how medical authority subordinated inmates.

While the labor of healthcare providers was not explicitly gendered by inmates in the same way correctional labor was, healthcare was still influenced and superseded by the masculine labor of the prison, evidenced in the often-repeated expression, “security always trumps medical,” similar to “police tactics” over “mother tactics.” It was in this context that fellow healthcare providers often pointed to the time, attention, and compassion their female colleagues sometimes demonstrated as weaknesses and evidence of their not being “cut out for” correctional work. Henry had the following to say about Claire and how she “lends her shoulder” to inmates:

You got someone like Claire who doesn't know how to say no to people. In some respects she's a bleeding heart. And if the same guy could keep coming back to her and working her for what he needs, he'd get everything he wants. You have to be firm and fair. You can't treat this inmate like this and then when they compare stories, now you've got a problem. Go by the policy. Give them what they *need* as a *patient*. Don't give them what they want. Don't give them everything they want, because the word's gonna get out and *you're* the one they're gonna want to come and see, and then the first guy you *don't* do it for, then you've got a problem. She... I'm not sure this is the right atmosphere for her. There are certain people that are not meant for this environment. Claire would be good as a nurse where she could see one patient at a time, and really concentrate on their needs, and what they.... I mean, in a nursing home you can basically order any med, not a prison. So some people here would be better suited in other environments.

A black female physician trained as an obstetrician/gynecologist who was working part time for the prison as a locum tenens provider faced similar criticism and the disciplining of her labor. When she was spending too much time with her patients in the infirmary, particularly making sure they were providing comprehensive care for a patient who was having a sickle cell crisis, the nurse who was waiting for her notes in the patients' charts turned to me and said, “She takes too much time with patients! That's just not how we do things here. She'll have to learn. By next week she'll be done in ten minutes, I'll bet!” In these ways caring labor was seen as gendered and therefore out of

place in a masculine, homosocial space – antithetical to the custodial-cum-punitive functions of the prison.

Respect and Recognition

As a result of the legal, interpersonal, and psychological boundaries placed on both clinical and custodial interactions with inmates, healthcare providers limited the kinds of involvement they would have with their patients and altered the ways that they talked about that involvement. Providers were able to use the gendered trope of respect to indicate how they could maintain the social intimacy required of a caregiving relationship without transgressing any of the prison’s boundaries. Respect has been shown to hold tremendous capital as a cultural expression of recognition, especially among men (Kleist 2010), and is given significant weight as a motivating factor for masculine social life, even as it can reflect a desire for patriarchal authority (see Bourgois 2003).

Most inmates, however, brought up dignity and humanity as desired aspects of their interactions with healthcare providers as a more precise form of respect, like Troy’s plea for human recognition above. Men frequently requested for healthcare providers to “treat me like a human, like a patient instead of an inmate.” These requests, whether they took place through the idiom of respect or not, called attention to what kinds of recognition inmates sought in clinical exchanges – recognition that took into account the complex circumstances of their lives and their depth as individuals. Rather than forms of respect that were rooted in recognition of men as economic providers or of high social standing (, 1996), both of which were negated in prison, inmates requested respect that functioned as recognition of their humanity and an empathic response that a healthcare provider would be expected to have in the face of suffering. Providers’ descriptions of respect with/for inmate-patients, however, revealed that the object of recognition remained undefined, and respect functioned primarily as a rhetorical device, taking on the representational significance of masculine reciprocity and authority without signifying any social or material evidence of it.

Dr. Keller’s narrative of his career trajectory and how he related humanistic patient care with respect in the prison context drew out these dynamics in an exemplary way. Dr. Keller’s interest in medicine came from a childhood fascination with anatomy.

As a kid he enjoyed putting together models of organ systems: “I started to do models that had to do with anatomy, models of the organs that I would paint different colors: the invisible head, the invisible dog, the invisible *man* [his emphasis]. I found all of that very, very intriguing. And that was the start of what I thought I knew that I either wanted to be or was supposed to be.” This anatomical focus led him to pursue science and then proceed to medical school, where he assumed he would specialize in surgery or another anatomy-heavy specialty. Once he gained more clinical exposure, however, he described feeling more of a connection with patient-centered care and enjoying getting to know patients personally, facilitating a switch to family practice:

I got to know [patients], and once I started to go into the hospital and work with other subspecialty groups, including orthopedics, I realized in many cases the patients [in these specialties] were just organs. And yet I kept thinking back to when I would do family practice and how well I got to know patients when they walked in the door, and how much more I enjoyed the interaction, you know, of who they were, not what organ they had. And then so that’s what made me decide through my third and fourth year rotations that I wanted to do family practice.

Dr. Keller described how when he started his job in the Philadelphia jails (his first experience in a carceral setting) part of “getting used to dealing with inmates” that continued in his work at Graterford was learning about respect: “I found that as long as I gave the inmates respect that I would generally get their respect back.” When I asked him to describe the process of earning and demonstrating respect, he displayed an awareness of the neglect and marginalization that accompanied incarceration and the potential of medicine in that context, but stopped short of a fully realized vision of respect that incorporated that understanding into his practice:

Dr. Keller: [Inmates] have a history of having manipulative behavior to get what they want when they want it. Some know very well how to work the system, whether that’s the medical system, the welfare system... of getting things that they need. [...] I found that if you gave them the time of day, which the legal system generally doesn’t, they – most of the people – would give you the respect back. And when I was working in Philly, I found many times that somebody just needed 5 minutes to talk to you about a medical problem. And throughout their life either because they didn’t go to the doctor, or because they were always in

trouble, or they were trying to manipulate the system, nobody listened and nobody cared. And obviously the police didn't care, and the correctional officers don't care, the judge doesn't care, because they're just concerned with the legal issues that involve that inmate. But I would come down and I would sit, and somebody would tell me a particular problem. I would discuss it with them, examine them, give them what I thought was going on and some sort of a treatment plan, and many times I'd get a handshake before I left, or they'd say, "You're the first person to actually sit and listen to me." And my feeling was if I give these guys the time that they want – *within reason* – then they're going to respect me back. And that's all I want is for them to respect me. The more they respect me, the more they're not likely to try to manipulate me into getting what they want.

Nick: And when you had those conversations with them, did you find that, maybe not necessarily their criminal background,²¹ but their social backgrounds and social needs crept into those conversations and altered your care for them?

Dr. Keller: Not usually. Not usually. Because the time was kind of limited, I focused on their medical issues. I may have had the chance to go more back into their medical history and ask them more pointed questions that maybe other providers, in an attempt to just move on to the next patient, didn't ask. So I would get more background from them about when things happened, and where they went, what other treatments they had, if they could remember any of the doctors and what hospitals they were at, to *engage them* in more conversation. And I think as long as they thought that I was engaged in conversation and I truly cared, they would treat me with respect and give me the information that I was looking for.

Respect could be seen as something that inmates needed as a marginalized population often disregarded in the process of institutionalization and bureaucratic management. Furthermore, respect was something that inmates could feasibly receive as incarcerated men given the other structural factors limiting personal engagement. As opposed to the taboos surrounding intimate and maternal care detailed above, respect occupied relatively neutral social and political territory and erred on the side of being perceived as masculine and therefore potentially in line with the gendered institutional identity of the prison. Given Dr. Keller's description, however, it became clear that respect more accurately reflected his desires for clinical interactions than those of his patients. That is, Dr. Keller and other healthcare providers at Graterford prioritized receiving the respect of inmates over having inmates feel respected themselves because they felt as though that would keep inmates from manipulating them and allow them to

get them to tell truthful medical histories. Dr. Keller used taboos about closeness with inmates, logistical complaints about time scarcity, and inmates' abilities to game the system in order to justify his position. What mattered to him was the illusion of care – that inmates thought he cared about them while still maintaining his distance, time, and authority as a gatekeeper to care. Rather than seeing the structural vulnerability of inmates as necessitating manipulation as a survival strategy, and using respect to address that vulnerability and provide better, holistic care accordingly, he instead used respect to win over inmates and keep his involvement with them “strictly medical.” The language and (not fully realized) practice of respect offered the opportunity to negotiate the gendered limitations placed on care, but still allowed physicians the kinds of authority that link care and custody to the subordination of inmates.

Dr. Keller's authority operated through this supposed respect in frustrating moments where the purely rational, Weberian bureaucracies²² that controlled inmates' lives were revealed to be imperfect or incomplete, yet persisted all the same. The boundaries around care and the impersonal treatment it renders that have already been described in this chapter and were referred to by Dr. Keller more generally in his comments reflect Weber's description of a bureaucracy that “the more [it] is ‘dehumanized,’ the more completely it succeeds in elimination from official business love, hatred, and all purely personal, irrational, and emotional elements which escape calculation” (216). Yet in the same description, Dr. Keller demonstrates how medicine in fact allowed for human compassion, revealing its capacity for interpersonal relations, assistance, and support in this context. The security functions of the prison and the bureaucratic management of inmates continued, however, despite or because of those spaces opened up by the notion of respect. In this way Dr. Keller's authority allowed him to both obscure power relations in the form of mutual respect and to seek them out anew in prioritizing his time, limiting the scarce resources of care, and evading manipulation.

One morning, during medical rounds in the prison infirmary, Dr. Keller and I started with an inmate from the RHU, who had been on hunger strike for a little over 10 days. This moment crystallized for me how Dr. Keller described his conception of and practice of respect in the prison setting. The inmate we were going to see was placed in

an MOC, a near replica of his cell in the RHU. In fact, the name MOC can be a bit misleading. He was being observed through closed-circuit television for the purposes of security, in order to “catch” him eating. The distinction of being under “medical observation” did not place him in greater proximity to healthcare; the contrary was true. Two sets of locking doors separated his cell from the rest of the infirmary, which was why we started with him. We needed an officer to unlock the doors for us to go evaluate him, as we did in the scene above where the female officer was yelling at an inmate. As we walked down the infirmary hallway, I asked Dr. Keller and the nurse a few questions: “Is it after a certain amount of time passes that they bring them up here...if they're on hunger strike?” The nurse responded, “Not really. Some of them stay in the RHU, so...” Dr. Keller interjected:

The policy says that unless we believe that medically their life is in danger, we don't need to bring them up as long as we have somebody go down there every day and see them. That's what the policy says, but every once in a while you have somebody on the block, people think they're cheating and getting food, so the deputy would say, “You know what, bring him up, put him in the MOC, we can watch him a little closer, and get a better idea of what's going on with them.” And that's why... that's why he's here.

The lieutenant opened the main door, but kept the door to the inmate's cell closed and locked. Dr. Keller pressed his face against the wall, aligning his mouth with the crack on the side of the cell door that allowed it to slide to the side when opened. Dr. Keller greeted the man, a middle-aged Puerto Rican still wearing his orange jumpsuit from being transported from the RHU and sprawled out on the cold linoleum. The man pulled himself up off the floor to sit on the side of his bunk. “How we doing? You alright? Mind if I come in and take a listen to your heart and lungs and make sure that you're okay? Or would you prefer that I don't?” asked Dr. Keller. Barely audible behind the metal and Plexiglass, the inmate put his head down, waved his hand, and shook his head at us, saying he was alright. Dr. Keller continued, “You're alright? Are you drinking at all? Have you discussed with somebody what your issues are? About why you're not eating, you know, what the problem is?” Because the man could still not fully be heard,

most of the conversation was relayed through the corrections officer was told some of the details of his case when he was transported from the RHU. After some back and forth between the officer intermediary, in which the officer just conveyed that the unit manager was aware of the details surrounding his hunger strike and one of the RHU nurses had been documenting his weight before he was transferred, Dr. Keller ended with an explanation of his role in the hunger strike:

Every day I'm gonna ask you if it's alright for me to come and take a listen to you. I don't know what your issues are. You know, I'm just here as the medical person to make sure that you're ok. So hopefully that will get cleared up and you'll be satisfied with whatever they need to do for you, but as a physician, I'm here to make sure that, you know, you look... ok. You know? I don't want to have to do anything against your will. I don't do that. But I want to make sure that medically you're also safe. When you go on a hunger strike you're basically committing suicide. And I understand whatever the issues may be, but it's a slow form of death. Um, if you want to refuse things, I can get to the point where I have to get a court order to do stuff against your will. I don't want to have to do that. I've never had to do that since I've been here. Ok? So hopefully your issues will be taken care of, whatever the process is, but every day I'm gonna come, while I'm here, and ask if I can come and examine you, get you weighed, have the nurses check your blood pressure, just so I can monitor how things are going internally for you. Ok? If you're having any problems, you're not feeling well, then you let me know and I'll address them with you right away. Ok? Ok.

With that he thanked the lieutenant for opening up the door and we moved on to the next patient.

Dr. Keller continually positioned himself as someone who was not involved in the security personnel's management of the reasons the inmate was on hunger strike in the first place. Those were squarely within the domain of the prison, and his role was just to make sure his patient was "ok" by checking in on him every day, lending him the time and attention he described above as respect. However, everything from the way he was housed to the threat to intervene on his "slow form of death"²³ with a court order attested that Dr. Keller's authority as a healthcare provider was completely in line with the security mandates of the prison. Furthermore, he did not make an attempt to understand the issue for which the inmate was on hunger strike and thus facilitate in its resolution to

provide better care for him. In this way, medicine perpetuated power relations through its own disavowal of them. It engaged in what Žižek calls, borrowing Eric Santner's term, a "crisis of investiture," an attempt to draw someone in by promising biopolitically optimized life without the adverse effect of regulation (Žižek 2004:506) – respect without invisibility, citizenship without subjection, care without custody. In circling back to the central themes of this chapter, Santner explains how this crisis of investiture can be particularly damaging through allowing the subject to simultaneously feel a sense of loss and alienation as well as a sense of intimacy with that against which he positions himself:

[A]n "investiture crisis" has the potential to generate not only feelings of extreme alienation, anomie, and profound emptiness, anxieties associated with *absence*; [...] a generalized attenuation of symbolic power and authority can be experienced as the collapse of social space and the rites of institution into the most intimate core of one's being. The feelings generated thereby are, as we shall see, anxieties not of absence and loss but of overproximity, loss of distance to some obscene and malevolent presence that appears to have a direct hold on one's inner parts (1996:xii\ emphasis in original).

In many ways the point of a hunger strike was to effect medical and legal recognition of bodily suffering to lend legitimacy to an inmate's claim against prison authorities. An inmate refusing to eat to the point of driving the staff to consider a court order to force feed him and keep him alive promised to bring attention to an issue of enough importance that he was willing to risk his health and life. Getting to that point only to have the medical staff take such a minimal role in that recognition and align with the security functions of the prison reveals both sides of the biopolitical coin – respect *and* invisibility, citizenship *and* subjection, care *and* custody.

Masculinity and the Medical Gaze

Not only did legal injunctions, labor norms, and rhetoric affect how inmates were seen as potential objects of care, but their bodies were also viewed according to raced and gendered configurations of embodied pain, strength, sexuality, and aggression. Building on Foucault's insights into how clinicians adopt a certain "medical gaze" to see patients

differently according the dictums of medical science (Foucault 1973), I turn to show how these configurations of masculine embodiment fused with biomedical understandings about the body, altering the medical gaze and how providers viewed – and thus acted upon – the suffering that presented itself in the medical unit.

In Foucault's account of the history of medical knowledge, he describes the trend beginning in the 18th century toward seeing the body as a set of interrelated yet isolatable parts. As diseases were more neatly categorized and taxonomized, so too was the human body and its discrete organs, tissues, and cellular structures. Medical practitioners therefore came to see the body in a particular way, to comprehend the symptoms of disease when they could be directly and completely linked to an organic problem within the body. This process turned scientific objectivity onto the individual, who was then seen outside their social context as an archetype of medical science. I'm interested here not just in the ways healthcare providers in the prison applied scientific objectivity to understand their patients' illnesses and how that articulated with the institutional logics of the prison, but also in the way inmates communicated their illness to be interpreted by providers. For Foucault, the medical gaze is not just a seeing gaze, but also "[a] hearing gaze and a speaking gaze: clinical experience represents a moment of balance between speech and spectacle. A precarious balance, for it rests on a formidable postulate: that all that is *visible* is *expressible*, and that it is *wholly visible* because it is *wholly expressible*" (142).

The ways that illness was expressed mapped onto perceptions of inmate masculinity in the way that symptoms were conveyed through pain or the loss of stereotypically masculine body features like weight and strength. In Foucault's analysis, the ability of a patient to express his illness in a way that related to a particular constellation of diagnostic symptoms was the only way medical truth could be evaluated and diagnoses obtained in medicine. This practice had particular purchase in the prison, where truth claims were constantly measured against both the threat of manipulation and a certain expectation of a stereotypically masculine illness experience. Furthermore, as we saw in Chapter 1, diagnosis necessitated action and treatment on the part of providers, so claims to subjective experience were heavily scrutinized for legitimacy. Furthermore,

treating objective medical data contributed to the kinds of dehumanization that inmates described because it was seen as a lack of human response to suffering. Roger explained, citing his mother's training as registered nurse, how this logic functions in and out of prison:

They gotta be neutral, I found out from her. Because you can't save everybody, so you gotta separate it and look at people like a machine. But my thing will be, I can't see how if somebody is hurt or injured, you denying them care, but they do that even on the street. So, they gonna do it in prison, and you know, I just think the humanity in people would touch you to wanna help somebody that need help.

Troy's experiences of healthcare at Graterford provide an entry point for seeing the expressibility and reductionistic interpretation of pain in the prison. When he was 19 years old, Troy was shot in the leg with a shotgun when he was caught in the crossfire of two rival groups of drug dealers:

I went to the Chinese store [corner store] to get a Pepsi at two o'clock in the morning. Before they started making those Chinese stores go down early. Guys from Cecil Square, I *heard* about it, guys from Cecil Square and 31st Street was going through it about some drug turf. I was walking in the middle of the street because I always said if somebody was after me, they would have to come off the pavement to get to me in the middle of the street, so if you was coming to get me or you was coming after me, you would have to get off the sidewalk. So I'm walking in the middle of the street. Like I said two guys in bikes, it's *July*, mind you. They got hoodies on! My dumb ass, not paying no attention that these guys got hoodies on in this 90 degree weather, they got hoodies on, and I see two guys on the step, they sittin' there smokin' weed. Then I see the blunt dropped out of his hand. Then I hear this scrambling of feet. I turn around, I look to the left, the guy got off the bike. I keep walking, right, while I'm looking, and I got damn near in the middle of them. So the guy got off the bike ... I'll never forget, he was shaking like this [*trembles, opens eyes wide, hands placed firmly and steadily around an imaginary shotgun*]. He had the hood on tied around his face. He looked like Kenny off of *South Park*. He's like this: "Boom!" [*flails arms and pretends to fall backwards from imaginary kickback*].

And then... it seemed like *The Matrix*, man. I seen that thing just coming and it went through my pocket. I see my pocket burst! My left pocket just went in shreds. Then he's still, "Bang, bang, bang!" This other guy's coming with the shotgun. He's shooting them, so... now I done broke into a limp because this [*points to his left hip down to his knee*] done went completely numb. Numb.

Spaghetti. So I broke into a limp. I went behind a car. The guys slide behind the car, too. They slide behind this little Chevy Lumina. So these two guys are shooting across the street at them [...] All of a sudden I felt like a fish on land. And I was like, “Why am I so *thirsty*?” Like I really felt thirsty like I hadn’t drank nothing. I was like, “What’s going on?” So I’m looking at my leg. I had a lighter, a hundred-dollar bill in my pocket. I had a metal keychain, and my cell phone. The bullet pushed all that into my leg. It pushed the keychain, bent it into my leg, broke the key off into my leg, it shattered the lighter into my leg, my money shredded up, everything. Everything was all pushed up into my leg. Then I’m looking at my shirt, like, “Why the hell does my shirt look like it went through a cheese grater?” So I lift my shirt up, all this [*points to his left side, from mid-torso down to his knee*] look like I was peppered, like someone poured pepper on me. I was like, “I’m gonna die.” I knew that I was going to die. I had a feeling about it. And I was so thirsty because I lost a lot of blood.

Getting shot, that don’t even hurt initially, cause you in so much shock. The healing process... phew. That is pain. Man. The draining [drainage tubes used in wound care] and the healing process of it... it’s crazy, man. And now I have a daily reminder.

Unlike some men, Troy had already gone through the extensive healing and physical therapy process that he described as being so painful well before being incarcerated. There were often men in the infirmary whose gunshot wounds from arrests were still healing and who had difficulty getting around on the block, so they had to be “housed” in the infirmary. Some of these men also suffered permanent paralysis or disability, which meant a long and often fruitless process of attempting to place them at an accessible facility. As only one such facility existed in all of Pennsylvania, access to it was heavily guarded and typically reserved for elderly inmates who required wheelchairs or men with complete paralysis who needed extensive assistance.²⁴ One man, who had been shot in the head by the police, experienced severe cognitive and functional disabilities that made it impossible for him to function outside the supervision of the healthcare staff in an MOC. Even despite his needs, placing him in a facility with assistance was difficult and required his enrollment in a research study conducted by an outside organization on traumatic brain injury, its role in aggression and impairment, and its implications for reentry in order to mobilize the resources required to provide ongoing care.²⁵

Nevertheless, Troy's constant pain was never seen as extractable from the other effects of incarceration and, in fact, seamlessly merged with them to create a complex and embodied experience of pain and loss. He was made to climb up to his upper bunk, walk across the prison campus to the dining hall, and continue on with institutionalized life where he could persevere on his pain, the trauma of his arrest, and navigating the institution to keep his head down and wait out his sentence. Reinforcing his sentiment that inmates would "wing it" and wait until something seemed life threatening to seek medical care, he was mainly concerned that medical care might delay his processing. Echoing statements that inmates often repeated during intake physicals, Troy emphatically stated, "If anything slows down my transit I won't bother. I'll just wait till I get to my home jail! You're in this transition here. It's the worst. They treat you like crap while you're in this jumpsuit. So I want to get out of here as soon as possible." Troy therefore actually relished in the invisibility and depersonalization of prison healthcare where he could suffer in silence as long as it meant he would be processed more quickly.

This changed when Troy began vomiting what looked to him like blood clots while on E Block and was thrust into this complex process of communicating illness. He told the sergeant on his block that he was vomiting blood, and we received the call in the dispensary that he would be coming up. After 30 minutes he was able to get an escort from E Block, where inmates in transit were held under higher security, and arrived in the dispensary. He saw Claire and began to talk about the gunshot pellets in his leg that had been left there as a result of his shooting: "I got shot back in 2000. I got 200 fragments in my leg." When Claire asked about the vomiting, Troy replied, "I was throwin' up like... chunks this morning, but you understand I got these things in my leg, this string. It's constant pain." Promptly dismissing the vomiting and assuming that his primary concern was his leg, Claire ordered an x-ray of his hip and leg. When the x-ray was completed, she and the other providers hovered around it in the dispensary, remarking at the presence of the shots and the general character of the image showing "something there that should clearly not be there." After seeing this, Troy's pain became self-evident. "Of course he's in pain, look at that leg!" one provider commented.

Claire called Troy back in from the hallway and prescribed him some anti-inflammatory medication despite the relative contraindication²⁶ and told him she would refer him to a pain management clinic that did not exist.²⁷ After Troy left and we had all reviewed the x-ray together, I remarked at how the original complaint we received over the phone had gotten so turned around, hoping to understand more about Claire's thought process and why she had prescribed an anti-inflammatory medication if he was vomiting blood. Claire turned to me, assuming I meant that Troy had switched up his own story, and said, "It's amazing how they can turn it on you like that! You know, he's pain-seeking." In his chart she wrote that he was brought up from the block with "suspected hematemesis [vomiting blood]," and that his "chief complaint" was "pain s/p GSW [status post gunshot wound]."

Skeptical of Claire's comments about Troy seeking pain medication, but wanting to understand Troy's motivations for seeking treatment that day in the dispensary more deeply, I questioned him about it during our first interview. When he immediately began talking about the pain in his leg and the circumstances surrounding the injury, I started wondering if Claire's assessment had been correct. Regardless of their motivations, inmates did sometimes seek out pain medication, but claiming to vomit blood to get to the dispensary and talk about leg pain seemed like a strange way to do that. After talking around the pain and what he went through to be seen, I asked directly: "So when you came up to the dispensary the other day, you came up for the leg pain?" He replied swiftly, "Yes."

Nick: Uh huh. Ok. So were you concerned about the blood - the blood in your vomit - or were you more concerned about the pain?

Troy: I was more concerned about the blood because when I vomited out in the street and there was blood, they told me a blood clot could slip from out of my string, so that worried me.

As it turned out, the pain and vomiting were causally linked for Troy and evidenced a deeper concern for the surgical repairs to the blood vessels in his leg after his gunshot, which he referred to as the strings in his leg. He had been told that blood clots

were a complication of the surgical repair and was nervous when he thought he saw them in his vomit. Remarkably, attention had correctly been diverted to the leg despite the miscommunication, even though the hematemesis was never addressed. Troy also felt as though the encounter had gone well because Claire ordered an x-ray, not realizing that she thought he was scamming her for pain medication. The x-ray satisfied Troy's desire to have the leg looked at to make sure there was no problem with the repair, even though Claire's evaluation of the x-ray was limited to proving the injury was sustained and looking for any obvious skeletal damage that could cause pain. While Troy wanted to avoid medical attention to avoid stalling his clearance, fear also motivated his avoidance of healthcare. He worried that if something were wrong, he would be left and forgotten about in the infirmary.

The universality of pain was a logical way to express medical need. Fortunately in Troy's case, despite the lack of commensurability in understanding the underlying issue, his expression of pain coupled with the visibility of his pathology served to legitimate his complaint. In many cases, however, pain was the source of skepticism by virtue of its exclusion from the masculine illness experience. When receiving injections or minor procedures, or even when presenting with any outward expression of pain, officers and healthcare providers would refer to inmates' tattoos, presumed gang activity, or even the status of masculinity itself as evidence of their imperviousness to pain – to ignore the experience or mark it as something out of place. Frequent calls for generic “gang bangers” to “toughen up” served as easy ways to both shirk off an inmate's complaint and also make him feel stereotyped and weak for having complained.

Once in the dispensary, Officer Cook was observing Dr. Khiabani perform an incision and drainage procedure on an inmate's neck abscess. The black, middle-aged inmate was too tall and lanky to fit fully on the dispensary's rickety gurney, so was forced to assume the fetal position while Dr. Khiabani operated. He squirmed in pain underneath the surgical drape, occasionally crying out in pain in short bursts. If he hadn't received an adequate amount of anesthetic for the procedure, it would not have been the first time I observed such an occurrence under Dr. Khiabani's scalpel. After a few outcries of pain, Officer Cook called out to him: “Oh be quiet, already! You the type that

shoot 10 mothafuckas in the street and you get up in here and start cryin.” The inmate’s response, between bursts of “ouch!” was to refute the claim that he was a violent criminal in order to justify his experience: “I ain’t no thug. I’m 50 years old. I’m a good ole boy. I’m here for robbery. I ain’t never killed nobody!” Similarly, in my conversation with Troy about his pain, he felt the need to preempt and refute any accusation that he might have a drug addiction:

They tried to give me Motrin, and like I told you, I’m like... I got 200 fragments, man. What do you want me to do with Motrin? Motrin’s not gonna.... This is not no break or nothing like that. I’m carrying metal around with me, man, like... that’s painful! How are you gonna give me motrin? I’m like there’s no way where I can file paperwork in order to get my medication? [...] They was prescribing me, Percocet. But I’m not a pill person out there, so Percocet was a little to high for me, so I guess they went down and gave me Vicodin, Tylenol 3. Yeah, like I was telling them, I’m not a real... I smoked marijuana before, but I’m not a narcotics person. I smoked cigarettes, and I can’t drink. I only drink like on occasion. I’m not, I’m not really a narcotics person out there. But they can’t give me the same medication. They’re like, “Oh no, we can’t do that.” So basically I’m, you know, just over it. The only thing I can do is just, you know, hope for the best.

In regular sick call visits, inmates frequently tried to express how dire their situations were through the universality of pain while managing the impression that they might be trying to manipulate providers. Many providers commented on the prevalence of leg and back pain complaints, and how these were often the hardest cases to deal with because treatment options were limited, diagnostic evaluation and imaging was logistically difficult, and the likelihood for manipulation was so high. The result was the systematic under-treatment of pain, a reflection of the broader societal disparity in pain treatment for racial and ethnic minorities (see Anderson et al. 2009; Pletcher et al. 2008; Shavers et al. 2010), especially for conditions with a dearth of objective findings (Tamayo-Sarver et al. 2003), and the under-recognition of pain secondary to explicit (Trawalter et al. 2012) and implicit (Mathur et al. 2014) perceptions that minorities, especially black people, feel less pain than white people do. In some cases these disparities are also structural, due to the lack of stocking medications in predominantly

minority community hospitals (see for example Morrison et al. 2000). At Graterford these issues coalesced with the exclusion of pain as part of the masculine experience in institutional policy – a policy that was rationalized by the prevalence of addiction and presumed abuse among inmates.

The breadth of the prison’s institutional policy on pain management was laid out and discussed in a staff meeting led early in the tenure of Dr. Diallo, the Ghanaian American physician who trained as a cardiologist and acted as medical director with Dr. Keller. The issues that complicated pain management and contributed to the inscription of bias into the prison’s policy were raised when the topic of stocking opioid pain medications on the prison’s formulary came up:

Dr. Diallo: As you know, a couple of months ago, Ultram²⁸ was de-non-formularized [put back on the prison’s formulary]. Well within a month or two, the usage of Ultram had just... gone through the roof. So Wexford I guess, saw their bill, and decided to put an end to that. Because now... [it’s] non-formulary. That’s fine because it helps with what I tried to do before. Remember we talked about decreasing our use of Ultram? So now, it’s not going to be decreased it’s going to be *stopped*. Those that already have an order, obviously will continue to receive. I just stopped by asking one of the pharmacy people, an inmate almost *assaulted* her because he wanted his Ultram and she said, “I can’t give it to you” because Guidice [the regional director for Wexford] had disapproved it today. So, expect a lot of the orders to be disapproved, and Ultram will be phased out, gradually. So, *do not* order Ultram going forward. Period. Uh, potential substitutes, think first non-steroidal – Ibuprofen, Naprosyn [Aleve]-type, um... those are the two options we want to go with for now. I spoke with Dr. Guidice and that’s the consensus that we’ve come to.

The other drug that has been non-formularized also is Neurontin, which as you know is second only to Ultram in abuse level.²⁹ So not only are we gonna decrease that use, we’re going to stop it completely. And again I discussed this with Dr. Guidice, and he has found some utility in substituting Elavil for Neurontin, and he’s also tried in some cases Keppra.³⁰ So these are your two options, and that’s the way we’re gonna go from here on. So Ultram and Neurontin - *out*, Ibuprofen, Naprosyn, Elavil, Keppra – *in*.

Dr. Khiabani: Let me ask you something. Can you, from your point of view, if you can write a letter, note, something to send to us so we can refer to that one, because you are not there or Dr. Guidice is not there when we are talking with the people. And they keep on insisting, but if they see instruction coming from you, and show it to them, it shut them up a little bit faster.

Lance: I had to throw somebody out of the office today, in pop [sick call for the general population]... almost bodily.

Dr. Diallo: Well that covers my two points in response to your question. Yes, I will send out what I just said to you, but... you have to move away from where you've been, where.... Listen, I know when you're in a room with an inmate, especially an intelligent inmate who is well versed ... Huh! [*chuckles*] He's almost a doctor! You know? [*everyone laughs*]... Yeah, and he's telling you what he wants. It's tough to say no. But we have to understand that *we* are in charge. They're inmates! They're not even real patients. They're inmates. They're.... This is a prison; it's not a hospital. So, they have to do what you say. Period! They may not like it. The worst thing they can do is write up a grievance. But you're in charge. You say, "This is what I'm giving. This discussion is over." If he gives you lip, you open the door, call in the guard, take him away. End of story. You don't even have to give him anything. If you don't think he needs anything, don't give him any! Call the guard to come take him away. The *worst* he could do is write up a grievance which I will respond to, okay? You're in charge.

Lance: Well he can also threaten lawsuits and so forth. They're very... uh, litigious here.

Dede: Yeah...

Dr. Diallo: Good, that's good! But you can't go forward with a lawsuit without... grounds. Who was I talking about with this the other day? If I don't have like a major fracture, bulging disc, something anatomical that I can point to on an x-ray or an MRI, I don't have to give you anything! You know what I'm saying? You can sue me all you want.

Lance: The only thing is we have to fight for MRIs and stuff.

Dede: Yeah.

Lance: If it seems legitimate then we have to, you know.... We fight tooth and nail.

Dr. Diallo: Well, the MRI thing, you know, is a collegial thing. It's money. It's a very expensive test, and collegial will do it only if you've *totally exhausted*... I mean *every... other... option*. "Well ok, let's get an MRI." So, that's the way you have to approach it, you know... when you're looking to do something. First of all, don't tell the patient, "I think you need an MRI." Never do that. And that's another change in practice we have to... I was talking to Dr. Douglas today. If you tell the patient, "Oh ok. Your x-ray is negative. I think the next thing to do is

an MRI, but I'll get back to you on it." Well, when you get back to him on it, you say, "Oh you know what, they didn't approve the MRI." *That's your lawsuit right there.* He goes, "Hey, Dr. A thought I needed an MRI, now I'm not getting an MRI!" So what you tell them is, "Alright. This test is negative. I'm not sure what we're going to do going forward. We're going to meet with a group of experts... and I'll get back to you, what they decide for us to do." So never give them more information than they need. Cuz you know these guys are already halfway doctors, and... you've given them all the information to make them even closer to being a doctor, then they just beat up the next doc that they need.

Dr. Khiabani: Can I ask something else? How about methadone? I have half dozen patient who are constantly on methadone. So would that be also the same as Ultram?

Dr. Diallo: So far it's not on the radar, and it's a fairly benign drug, relatively. I wouldn't go crazy about it in terms of the guys who are already on it. Just, you know, tread with care in terms of going forward and prescribing it.

Lance: I know Dr. Douglas had renewed the Ultram for a patient, and the guy came to me today... matter of fact I think it was the *captain*, came down to my room demanding why this person had not been given his medicine.

Dr. Diallo: Yeah, we're gonna get some backlash initially, but it will go away.... It will go away

From concerns about inmates knowing too much about their conditions, avoiding lawsuits, managing costs, eliminating the use of all opioid medications suspected of abuse, and the requirement of observable pathology, this highly concentrated moment in the staff meeting addressed all of the lenses that affected how providers structurally viewed pain presented in the prison clinic. These lenses collapse onto each other in Dr. Diallo's framing: "They're not even real patients. They're inmates." As inmates, the reliance on objective, visual pathology became the hallmark of engaging with their experiences of pain, only insofar as they represented the threat of inmate retaliation and obligation to treat by expending limited resources. This served as another instance in which healthcare providers within the prison were able to redefine medical need, especially for certain pain medications, based on this policy that was expressly informed by a devaluation of gendered experiences of inmate pain.

It is also worth noting the relative laxity with which Dr. Diallo treats methadone. An opioid medication used in the long-term management of opiate addiction, methadone has historically been marketed to and used with black patients in state-sponsored clinics, and this distinction continues to be reflected in its use with black patients over the now more advantageous buprenorphine. Thus there is a structural racial segregation in addiction treatment in which methadone is associated not only with addiction, but with black addiction (Hansen et al. 2013), and management of pain becomes mired in the inertia of continued methadone therapy. The reliance on methadone as the only opioid medication still used for pain management in the prison perpetuates these linkages between race and pharmacotherapy, merging them with perceptions of masculine pain tolerance. In some cases, as in Roger's case where he was assumed to be a heroin user because he was chronically prescribed methadone for pain, these linkages created adverse and unintended consequences. Roger even recapitulates the advice that he was given when receiving chemotherapy outside the prison was to report pain, but how futile that is in the prison: "Even the paperwork during the chemo said, 'Don't try to tough it out, report pain,' and all that. You report pain in here, they... they don't care! They try to take it away, give you an aspirin."

Some of the formulary changes even meant that inmates would be taken off their pain medications, and then have to put in sick call requests – sometimes after going through painful withdrawals – and be forced again to make the argument to be put back on them or to have the provider make whichever relevant substitution they were applying at the time. Once, Mr. Thomas, a black inmate in his thirties with Hepatitis C, came into the dispensary with pain. He was previously prescribed diazepam, a benzodiazepine, as an alternative to opioids and non-steroidal medications (which have negative effects on the liver), but it was discontinued after being taken off the prison's formulary. As was often the case with medication changes, Mr. Thomas was not made aware of the fact, and his medication simply was not available when we went to the medication line on the block to receive it. When he said that he would like for it to be renewed, the nurse in the dispensary – a white woman in her forties – said plainly, "That's not how we do things anymore." Mr. Thomas replied, "Ok, well you'll just get my records and then after I've

gone through withdrawal you'll prescribe it for me, and I'll just have to keep going through this." Frustrated and not fully understanding all of the medication changes, Mr. Thomas kept repeating, "Why you gotta make me suffer?" Eventually the nurse gave him some Immodium to ease the diarrhea that would accompany his withdrawal and a one-time dose of a muscle relaxer and sent him back to the block. Afterwards, the nurse turned to me and said, "I'm writing 'drug seeking' in his chart. That will put an end to that," relying on and reinforcing the categories of manipulator and drug user to systematically deny the existence of pain and access to pain management.

In addition to pain, the presentation of certain illnesses involved lamentations of weight loss and muscle mass to reflect a loss of control that was channeled into a loss of qualities associated with masculinity. Mr. Morton, a white inmate from a rural county in Pennsylvania west of Philadelphia who was serving time on a parole violation, first appeared to sick call complaining of drastic weight loss. He appeared frequently in the medical unit and was always seen by the healthcare providers as someone who was "hot tempered" and "attention seeking." He had white hair kept in a buzz cut, was short – about 5'5" – and spoke urgently, barely getting one sentence out before starting the next. The providers interpreted this as him feeling entitled and having a "short fuse."

Mr. Morton ran through his history at one of his sick call visits: "Doc, I weighed 160 when I came in this jail! Now I'm down to 135, 140... In a matter of a couple months? You can't tell me something's not wrong with that! Something's up here! I been telling them I need some meal bags, something! Prescribe me some Ensure, I don't know. But this weight loss is no joke. It's not right!" Dede, the provider who was running sick call that day, reluctantly looked through his history, detailed in his medical chart, which conveyed a host of similar complaints over the past few months. Before I had met him, Mr. Morton's lab value for his level of thyroid-stimulating hormone (TSH) had been read incorrectly and he had been diagnosed with *hypothyroidism*, which slows down metabolism and typically causes weight gain. The correct diagnosis was *hyperthyroidism*, which was exacerbated when Mr. Morton was put on synthetic thyroid hormone to treat his supposed hypothyroidism, accelerating his metabolism even more, and contributed to his weight loss.

The staff was in the process of rectifying the mismanagement and diagnosing the cause of his hyperthyroidism so it could be properly treated. Because his weight loss complaints were seen as part of his desire to seek attention, my interpretation was that they were not necessarily taken into account fully in the diagnosis, which was instead based primarily on the lab value, which could have indicated either diagnosis depending on the cause and associated symptoms. In this interaction, Dede mentioned his preliminary diagnosis and outlined a partial plan: “You have an issue with your thyroid that we are working on fixing, but it is a process. You know this. You know there is something wrong with your thyroid. It takes time.” Mr. Morton knew that he had an issue with his thyroid, but was not told about the original misdiagnosis; instead, he was told that there was a process of “trial and error” in finding the correct medication and dosage. His concern and urgency was a byproduct both of his suspicion that his medical complaint was not being managed well and his heightened activity, nervousness, and anxiety from the medical condition.

The primary symptom that concerned Mr. Morton was his weight loss, especially compared to his weight prior to incarceration, constitutive of the loss of virility and strength with his re-imprisonment. When I asked him why the weight loss was such a concern for him, he replied:

That’s how I know something is wrong. I’m tired all the time, not myself, a wisp of a thing. I know they’re not feeding me right and they’re not diagnosing the bigger problem. I have to get other guys to give me some of their food, sneak some, so I can put on some weight here! But trust me that I know some important people. Once I get out I can talk to my lawyer friends and maybe they can help me get to the bottom of what’s going on here.

Weight loss was not only an urgent way to convey the direness of his condition within the timeline of his incarceration and a convenient way to characterize Mr. Morton’s illness experience, but it also served as a mechanism to consolidate complaints about needing to rely on other inmates for adequate nutrition over the institution, whose inability to provide sustenance he also suspected was causing his weight loss. Both of these issues motivated his request for a supplementary meal bag. The providers read his

desire for meal supplementation as a “comfort” issue rather than one that was explicitly medical, and was therefore deferred like requests for synthetic blankets because of allergies, extra mattresses for back pain, and bottom bunk status. Furthermore, they continually displaced his anxiety about mismanagement and persistence in seeking medical attention onto either his personality or rarely onto his medical condition, not the management of his case or the heightened suspicion that goes along with incarceration. The expression of Mr. Morton’s illness, his associated requests, and experience of incarceration were all disarticulated in the management of his illness, which alternatively relied primarily on lab values or using his symptoms against him.

Another example of the expression and medical interpretation of illness in the clinic involved requests for and talk about testosterone. Occasionally, inmates would make specific requests for testosterone supplementation that caused interpretations of illness to dovetail with the loss of masculinity, nutrition, and loss of strength. Providers cited a desire to build muscle and supplement their weightlifting as the reason behind inmates’ requests for the hormone, and stated that they only fulfilled the request in the case of a laboratory test documenting a deficiency. Most inmates that I spoke to cited nutrition as an associated issue of importance that could create a hormone imbalance. These themes were often expressed in clinical complaints of the increased consumption of soy in inmates’ diets, which both expressed the deficiencies they saw in the quality of food they were given and a loss of masculinity or qualities associated with masculinity. Soy, which is a source of phytoestrogens that can mimic natural estrogen, replaced many meat products in the inmate’s diet because it was a cheaper source of protein. In some cases this resulted in the specific inmate request for testosterone supplementation to offset the effects of the phytoestrogens. Darrin, who sued for access to his medical records in Chapter 1 worked in the prison’s kitchen and expressed concerns about the quality of meat they were served:

Darrin: You know, here, I work in the kitchen, so I’m always snatching labels for meat, and it’s like, “Yo, there’s not even meat in this. What is this shit?” So I’m tellin’ guys, “You need to stop eating that shit. That’s not even meat.” All life source has a blood or something. This stuff is dyed.

Nick: You say it's dyed?

Darrin: Yeah, it's dyed! The stuff that's supposed to be blood, it's really dye. You shouldn't be eating that. But what can I do, you know? I can't... Christ, I can't say any more. I just don't eat it. But I try to tell guys, like... cuz guys obviously complain after the fact. I'm like "Well, keep informed and stop eating it. They can do better. You can make them do better, just don't participate. Just don't eat it. If you don't eat it then they can't buy it." Logical guys don't eat that.

Rather than requesting testosterone, Darrin channeled his frustrations into continually expressing his desire to get fresh produce and applying for kosher meals that he had heard provided real meat and more vegetables. I talked with him about how the prison used to contain a fully functional farm and operational dairy, which would sell its products to neighboring towns. Operational costs and lack of profitability shut down the farm in 1999 after 70 years of use,³¹ but the over 800 acres of farmland was never used again, even to sustain the prison's own food costs because statewide prison food services were contracted to private companies. He and many of the healthcare and correctional staff I spoke to thought it would be a great idea to have a sustainable farm cover or at least supplement the food needs of the prison, and also have the benefit of offering inmates a form of masculine labor whose fruits they would enjoy themselves. In response to the state contracts mired in political bureaucracy, however, they all had a similar version of the same response to why that would not be a possibility: "somebody's washing somebody's hands." The entire prison services system had become so heavily monetized and entrenched in state bureaucracy and legislation that such a commonsense, local solution became a logistical impossibility. As a consequence, not only were food rations tightly budgeted and comprised mostly of carbohydrates and salty canned foods, it was also nearly impossible to get special diets for medical conditions like diabetes. Instead the providers often assumed that a nutritionist had reviewed prisoners' diets to make sure they met nutritional needs and fit a heart-healthy, diabetic lifestyle. As one provider mentioned, "According to the prison, there is no such thing as a diabetic diet... or a hypertension diet for that matter. They say the whole diet of the prison is designed fit those needs."

While weighing Eddie one day in the dispensary, we discussed diet, and he commented about how he had heard that all the soy that they fed inmates could give you “man boobs,” a condition called gynecomastia where the phytoestrogens enlarge breast tissue: “I was eating the meat in here, but have you seen what passes for meat here? And now I hear they cut that with soy, and soy they [other inmates] be tellin’ me acts like estrogen. It can give you like man boobs and stuff!” He joined many other inmates in their concern about this condition and started a push-up routine to offset the development of more drooped, feminized breast tissue. Though perhaps not typical, I would offer that workout routines like the one Eddie adopted were less an part of the independent identity of individual inmates (i.e. that inmates had an independent desire to present as strong and muscular) but rather a response to the social, nutritional, and chemical causes of emasculation and illness during incarceration, an effect of the melancholia of masculinity.

Despite the fact that providers insisted testosterone supplementation existed as a way to augment weightlifting and build more muscle mass, they were aware of complaints about the consumption of excessive amounts of soy. In fact, they often remarked what a great idea it was that soy was a cheap alternative that also had feminizing effects that might “calm” inmates’ hypersexuality and aggression, reinforcing testosterone as the reductionistic, chemical source of masculinity. After a call to the dispensary to send one of the medical unit’s inmate-workers out for a body fluid cleanup because an inmate had masturbated in one of the prison’s public areas, Dede casually mentioned feeding inmates more soy “so they get more estrogen.” “It can’t be a bad thing!” she said. “It might make them... *calmer*. You know what I mean?!”

There were also many times in which multivitamins were taken on and off the prison’s formulary. Men would request them to supplement their inadequate diets, and for the most part (especially with older men) these requests were granted. To cut costs, however, multivitamins and other over-the-counter medications were sold in the prison’s commissary, so inmates would incur the cost of purchasing these drugs that were seen as “non-essential” or for which there was no documented “serious medical need.” During one such time, Claire mentioned how providing multivitamins was “cheap insurance”: “It

shows we care, and it's not that expensive to provide, even if they're not deficient." Her comments then quickly shifted to complaints of low testosterone: "It's not like low T. We actually *like* low T. They [inmates] keep telling me, 'They're turning us into women by feeding us soy.' Feed them more soy! Might make them less aggressive, keep them calm!"

Prostheses

Until now I have mostly described the ways the gendering functions of the prison distanced inmates from care despite their heightened need for it, and how constructions and experiences of masculinity affected the structural elements of prison healthcare. I now turn to discuss the lived realities of Eddie's illness and incarceration together with the theme of masculinity through the ideas of loss, recuperation, and adaptation. The amputation of Eddie's right leg, which followed a partial left foot amputation, serves as a profound symbol of the multiple losses that Eddie endured. He relayed these losses on multiple occasions, framing them as "tests" he had to face. While we sat near the end of the hallway of the prison's infirmary one afternoon, where I pulled up a foldout chair next to his wheelchair, Eddie massaged the lower part of his thigh just above the amputation stump: "You know, I consider all the ways, all the hardships I've faced in my life... I see them as tests. Losing my leg... that was one of the top three tests of my life. Number one is that I been incarcerated 42 years. Number two was losing my mother, especially while being in here. And number three was *this right here*."

After the amputation, Eddie waited for three months in the infirmary before being fitted with a prosthetic leg so he could return to the block without crutches or a wheelchair. At the same time as this gave us ample opportunities to have extended conversations about his life, perspectives, and experiences, it kept him from having access to his legal paperwork to pursue his appeal and from carrying on with daily activities in the prison, which included his involvement in some prison groups and outside organizations. Although he wanted the prosthesis, actually obtaining the device felt more like an externally imposed requirement to return to the block than a necessity for his daily life, and the delay in fulfilling that requirement frustrated him. However, once he got the prosthesis, it did facilitate his mobility – both in the literal, physical sense

as well in the figurative sense, allowing him the mobility to continue the efforts of fighting his charges and enduring the vagaries of prison life. The prosthetic leg served as an apparatus – a tool to help him accommodate to the conditions of incarceration amid the loss of his leg and the associated loss of his physical abilities and strength.

Rather than seeing the prosthesis as an artificial appendage to an incomplete body or as a seamless extension of himself, he saw it as a machine that enabled him to keep moving forward – making progress toward leaving the infirmary, pushing his case forward, and improving his health. He often compared the prosthesis to a car. Once, when describing another inmate who came into prison with a more modern prosthetic leg,³² he referred to the prostheses as two different car models: “He’s got a 2015 Mercedes, and I’ve got a 1963 Ford!” The sentiment simultaneously referenced the outdated technology used in the prison and the nature of the prosthesis as a commodity and a masculine device for mobility. In another instance, while discussing the tests that he had faced, Eddie looked to the future and “passing the next test,” being able to “move through the minefield” of the prison, navigating different personalities and expectations. At this mention Eddie immediately jumped back to his leg and the anticipation of the prosthesis, making explicit the connections between the hardships of incarceration and the need to adapt that a prosthesis would facilitate: “You know, I wonder how they’re tryna do me with this leg. I’ve been off the block. Everybody’s been so sympathetic and empathetic. I’m not used to that. I’m gonna get that prosthetic limb so I can get on, moving around on my own.” To Eddie, mobility meant not occupying a position of vulnerability or fragility, even if that meant leaving a “caring” environment in order to face other challenges.

It is with the metaphor of the prosthesis that I want to think through Eddie’s incarceration, illness, and masculine identity. As an assisting and adaptive device – though one that may not even be desired or ideal – a prosthesis enables a certain kind of literal and figurative mobility after loss, as a newly configured body creates and redefines relationships to the physical and social world (Wigley 1991). In the face of his tests, Eddie reacted, recuperated, and recalibrated. His prosthetic leg became not just a material reminder of bodily loss and a new way to physically navigate the prison, but a broader symbol of change in response to loss and isolation. Hence, I am using the framework of

the prosthesis not to make particular claims about the subjectivity of amputees or the phenomenology of prosthesis use, but rather to link conceptually how Eddie lived with the physical and social injuries he endured *as* a ward of the state and *in* a ward of the state. Prostheses therefore operated not necessarily as tools to overcome the gendering functions of the prison or to improve upon a baseline physical and social condition, but as incorporations of loss, suffering, and injury into daily life. Considering disability as the integration of social relationships with biological pathology, where relationships to injury are formed between both an individual and the self and an individual and the community (Ralph 2014), I look to Eddie's experience of physical loss and disability to illuminate the re-making of embodied and social/civic masculinity under state custody.

Taking Eddie's three tests in turn, first, his incarceration, like Troy's, represented a loss of citizenship tied to the possibility of performing masculine social roles. This loss was tied to the idea of masculinity he had developed in his youth by seeking out male bonds prior to his incarceration in the 1970s. Given what he described as the relative lack of "strong, male role models" in his life, he admitted to being involved in a gang during his youth that offered him opportunities for male bonding, protection, and reciprocity:

The gang to me, its like a family – like brothers. They were something that I didn't have. I had all sisters, and the only male cousin I had was a homosexual, so I couldn't get that [masculine influence] from him. It was a different vibe. That's why you got the boy scouts and the cub scouts and all that. I even went to an all boys' school. That's how I grew up. [The gang] actually started out as a little league baseball team! When somebody was having trouble, we stood up for him. One thing led to another, and all of a sudden we a gang! Something as innocent as that!

Eddie described how his gang of teammates became involved in some misdemeanor criminal activity as a result of the escalating stakes of standing up for one another.³³ Eddie had to balance the protection and masculine camaraderie that the gang provided with this activity that caused him to have various run-ins with the police during his youth. By the time the gang's criminal activities started to become an integral part of its identity as a family or brotherhood, so too had Eddie's masculine identity become deeply entangled with militancy and embodied reactions to racial oppression. He

described one incident in the late 1960s where he and his friends were brought in front of a judge as juveniles for throwing paint on someone's house. His case was being heard on the same day as that of a young white man who was charged with arson after setting fire to his neighbor's house. Eddie remembered the judge, after deciding that he would be brought into custody, remarking on the white man's case: "We don't want to send him over to the [juvenile center] because, you know, bad things happen over there, and he's a reasonable kid, so we're going to send him home in the custody of his parents until the hearing next week." He continued, "You see the discrepancy, and if you see those things as a kid and say it didn't have no effect on you, you a damn liar. So, I'm not using nothing as an excuse for my behavior, there was a lot of things I did that wasn't right. I see it as acting out. I see it as rebellion, but it's not an excuse. There's no excuse." Though he assumed a standard narrative of taking personal responsibility for his actions that broke the law, Eddie admitted that they were driven in part by a response to racial animosity and prejudice that he faced, causing the kinds of interpersonal retribution and retaliation that the gang engaged in to take on broader significance.

Eddie described a period after his incarceration when he reacted negatively to officers holding power and authority over him and would "push back." This gave way relatively early on in his incarceration to taking an approach similar to Troy's of isolating himself from staff and other inmates. This trajectory partly tracks the distinction that many staff members made between so-called "young bulls" and "old heads." As staff described it, the former were more aggressive and galvanized by the idea that they would eventually be released, that they had something to fight for. Old heads, in contrast, especially those serving life, had "mellowed out" after years of institutionalization and, according to some of the healthcare providers, "realized that they stood to gain more by working with prison staff rather than against them." However, in my perspective, all inmates demonstrated and conveyed that they had "something to fight for" and alternated between keeping to themselves and strategically advocating for themselves given the institutional restraints they faced, be it "with" or "against" staff. Eddie, as an old head with a longer sentence in fact eventually became more comfortable and outspoken in specific contexts compared to Troy, who mainly kept to himself, reversing the

distinctions between these generational groups. The contexts in which Eddie adapted were first, in private conversations with staff he knew well, and second, through the mentorship of younger members of the prison's general population, through which he effected a paternal presence to make sure younger inmates "don't get complacent in the penitentiary."

Taking on this paternal role forced Eddie to alter his perspectives on the forms male bonding could take and on the self-professed homophobia that guided his interactions with his gay cousin during his youth and caused him to draw clear boundaries around appropriate social relations between men. He recalled that he had gotten close to a younger inmate once who was good at spelling "though you wouldn't know to look at him." Eddie admired this trait in the young man – a trait he said he lacked himself – but did not fully understand at first when the young inmate began to feel closer to him:

One day he thought to come into my cell, and me being an old convict, he sat on the bed right next to me, and I'm thinking maybe he's a homosexual or something! That homophobic thing jump right in your head. I thought, "Man, I was trying to help him and all that." But it wasn't that. It was the bonding and the closeness to an older guy, like he never had his father or nothing, and he was like hugging me you know? It was a bonding thing. He wasn't a homosexual. It had nothing to do with that. I was just one of the first, in a long time, guys that he had got that close to. And I had to look at that and some of my old thoughts I had to get out of my head. I thought he was trying to come on to me! Some kid sitting that close to me, I'm moving over! But it was just... it was *pure*. It was real and it was pure. He wasn't trying nothing. It was just that, a new relationship and a close relationship with an older guy, that he never had with his father or uncles or nothing like that. And like I said when a lot of times you try to teach, you learn too. And that was the situation with me. I learned something that day. And it was beautiful. He's stepping up and I'm stepping up, too.

Eddie's mentorship of fellow inmates also involved teaching younger men to read. He said he would often use erotic literature to keep them engaged and interested in learning: "I taught them with stuff that kept them entertained, kept their attention. I was teaching them from all kinda smut." He also involved himself in an outreach organization called the United Community Action Network (U-CAN) that provided education

scholarships and a hopeful message of education over incarceration with the catchy slogan, “Go to Penn State, not State Pen.” Eddie mentioned proudly how he and other inmates would contribute their meager wages to promote these goals: “We have these groups in this institution, and we do good work. With our little pennies, I get 20 cent, 15 cent an hour, we give scholarships every year to the community. I think this year we gave out six scholarships with our own pennies, to help kids go to school to educate theyselves.” Eddie also participated in the Philadelphia Mural Arts Program’s “Restorative Justice Project,” which worked with men incarcerated at Graterford to design murals around Philadelphia, usually exploring themes of fatherhood, and in the prison’s chapter of the Grey Panthers, which advocated for “age-out” legislation and an end to life without parole sentences, or what activist organizations call “death by incarceration.”

Although different in their approach to civic-mindedness because of their sentence lengths, Troy and Eddie similarly experienced the familial disconnection of incarceration. Eddie felt compelled to divorce his wife, saying “I wanted to give her that. I didn’t feel like it was fair to her to keep her bound to me.” The separation from his children was also difficult. He admitted that his mentorship in prison helped assuage the guilt he felt, however: “One of my real regrets in life is that I never had the opportunity to put my own mark on my own children. But now I got hundreds of ‘em that I could talk to! I’m like, okay... I missed that, but I like this.” Eddie found a new outlet for expressing the kinds of paternal guidance and mentorship that he could only give in infrequent visits in the prison’s visiting room or over the phone. Although Eddie regretted not being able to be a typical father to his biological children, he suggested that his relationship with his daughter actually improved as a result of his incarceration. Eddie said, “We were forced to talk, and confront the deep issue of my absence.” The reconciliation of their relationship was not easily won, however. His daughter, who now lives in Texas, told me, “It took me years to realize how deeply his incarceration affected me. I had to get therapy for that right there. It was *real*. And I didn’t even know.”

Eddie experienced his remoteness from assuming a typical familial role most acutely during his second test, when his mother died. An avowed “consummate mamma’s boy,” Eddie recalled the moment where the weight of her death hit him the most:

When they came and told me that my mother had passed, they did one of the worst things they could ever do. I didn't know it was going to be that bad. They called me down to the chapel. They had taped the funeral, and they had it in the room. When I went in the room and looked at that tape... I had to, it took me 15, 20 more minutes to get myself together just so I could leave the room *after* I seen it. [...] I didn't know I'd be in that room alone, me and that tape. That done beat me up. I was sorry I came in there! I had my memories of her. I wanted to keep those. Seeing in that tape that everything is final, I had to deal with some stuff that I had buried, you know? And I had to get control over myself before I left that room. They told me, "We got this for the next week if you want to watch it." I told them "You can send that back *now!*"

Eddie had found out from his family weeks prior that she had passed away and worked with them to help arrange for her funeral. This meant keeping his composure and strength in order to take on the role of the man of the family: "I surprised myself! Seriously. I was surprised at how, because I had to be a certain thing for my family, when they came up and talked to me and take care of the funeral plans. And I took care of things without losing myself, even though that was tearing me up. But I handled the situation because I had to be the man of the family." Eddie's surprise, he said, came from his ability to handle hardship during incarceration and work (albeit in a limited capacity) to fulfill a filial obligation, where he said many other men would become depressed and even suicidal.

In the final test on his ordered list – the loss of his leg - Eddie's loss took physical form. He had organized them that way purposefully, he said: "Cause today if they asked me you could have your foot back or your mother back, that's a no-brainer. Or if they woulda said, 'Look, lemme take one of two things, your mother or your foot.' C'mon! And take the hand too! Leave mom alone." Eddie had first been diagnosed with type 2 diabetes in 2011, though he did not recall diabetes being mentioned to him until 2014, around the time I had first met him. Diabetes causes damage to blood vessels, making wound healing difficult, as well as damage to nerves, diminishing pain and making wound detection difficult. Healthcare providers' understandings of the disease process affecting his circulation were complicated, however, by the fact that he was also diagnosed with vascular insufficiency, and diabetes was not consistently mentioned in his

medical chart. After the partial amputation of his left foot, when he began coming to sick call visits in early 2014 complaining of pain in his right foot from an ingrown toenail, the medical management of this new pain was muddled by imprecise diagnosis and documentation. Based on the incomplete documentation of the disease process, the staff was confused about whether the injury had the potential to heal on its own since he was actually feeling pain or if it should be treated as a diabetic ulcer or would be complicated by his vascular insufficiency. The providers decided to have him see a vascular specialist. By the time that initial consultation was approved a few months later, the specialist suggested a partial amputation of the right foot because the infection from the ingrown toenail was unlikely to heal because of Eddie's poor circulation. Two months after that consultation, part of his right foot was amputated. The flap for that initial surgery was not constructed or closed well, so it eventually got re-infected, and the remainder of the foot became gangrenous.

Eddie waited three more months in the infirmary following the partial amputation for a new orthopedic consult to be approved for the gangrenous foot in "collegial" - the weekly utilization review meetings held between the providers at Graterford the healthcare contractor Wexford. This is when I met Eddie – in a period of painful waiting, not knowing if he would keep or lose what was left of his foot. Although Eddie did not know it, one early evening when I was walking the infirmary hallways preparing things for a few of the patients with Silvia, the somewhat soft-spoken and timid Peruvian nurse who covered the infirmary, she and I saw him crying in his infirmary room, which was one of the single-bed rooms used for infectious isolation. Silvia admitted to me that she had heard him crying in pain sometimes at night, and she spoke against the delays put forth by the collegial review that I described in Chapter 2 as pushing people further along the trajectory toward "serious medical need" before suffering is recognized: "The collegial I believe was one of the big reasons he is gonna lose the leg. It is like inquisition! They say, 'No, it's not going to happen,' or 'Wait one month, two month.' They want pictures of the wound before they will approve, everything. It is awful!" Silvia acknowledged that her rare moment of outspokenness and acknowledgement of suffering was a result of her witnessing this private moment. As opposed to presentations of

medical claims in other settings that providers viewed as performative or argumentative, seeking claims for legitimacy and authority, this expression was not for an audience, causing Silvia to admit, “I feel sorry for him.” Eventually the company did approve the request to revisit the orthopedist, who by that time recommended a second amputation on that limb (his third overall), this time below the right knee. Eddie mournfully described how he felt the opportunity to save his leg slip away: “They said they’re gonna cut it right here [revise the original amputation, pointing toward the base of his foot] and shave the bone, and try to do it in two weeks. When I had come back a month later, the gangrene had spread. That’s a fact! Because they had waited. And then they said to me, ‘Eddie, that option is off the table.’”³⁴

Facing the test of losing his leg, like facing the other two tests, required breaking with his prior notions of masculinity and both finding and adapting to a new place in the world. He had to re-learn how to enable his body, to reconfigure his position within his family (even make new kinds of family), and to forge new bonds of citizenship where those with the state had failed him. Eddie faced these tests with multiple prostheses that ironically arose from his relationship to the prison healthcare services that contributed to the loss of his leg. In addition to his physical prosthesis, Eddie had received advice from medical staff many years prior that allowed him to see the biological and embodied aspects of masculinity itself as prostheses. He said of his ability to adapt:

That’s been one of my saving graces in here, that I could take things lightly. When that doctor told me to go to the cell sometime and let it out, because of my blood pressure. He said that burying things like that could be the cause of that blood pressure being up like that – that men sometimes bottle it all up and don’t let it out. Stress can be a hell of a thing. That right there will kill you, but it manifests itself in different ways.

Eddie’s reconfigured the bodily effects of adaptation from unhealthily suppressing his feelings to expressing them in order to make light of them based on the advice he got for dealing with stress. This advice allowed him to rethink the emotional expression of masculinity as a prosthetic to adapt to changing social and psychological circumstances rather than being stuck in the disabling stereotypical role of masculine stoicism

Eddie drew on notions of performed gender that were improvisational; he made do with expressions of masculinity that fit the specific material and cultural contexts in which he found himself. The improvisational style of masculinity is especially called for in prison, where inmates may alter their normative visions of manliness to confront the different interpersonal, physical, psychological, and political challenges they face in that environment (Nandi 2002). In his essay, “Are You a Man or A Mouse?” Homi Bhabha describes what he calls the “prosthetic reality” of masculinity in psychoanalytic terms (1995:57). Masculinity, like the prosthesis, represents a difficult reckoning between the self and the prosthetic and between what is represented and what is experienced. The gaps that one must bridge in this reconciliation represent the losses (or “lack” in psychoanalytical terms) that one attempts to recuperate with the prosthesis of masculinity. Bhabha writes, “My own masculinity is strangely separating from me, turning into my shadow, the place of my filiation and my fading. My attempt to conceptualize its conditionality becomes a compulsion to question it; my analytic sense that masculinity normalizes and naturalizes difference turns into a kind of neurotic ‘acting out’ of its power and its powerlessness” (1995). Similarly, Eddie’s utilization of his prostheses represented reconfigurations of family and psychosocial relations within the prison. The prostheses reflect both the loss of his biological family and social networks outside the prison as well as the recuperation of kinship ties within the prison; they reflect the power of reconstituting citizenship as well as powerlessness of being under state custody.³⁵

Eddie’s physical prosthesis itself also represented such difficult reconciliations and the links between prosthetic masculinities and his prosthetic leg. After months of uncertain waiting for care – first for surgery, then for the prosthetic – punctuated by multiple, escalating amputations, Eddie finally got the prosthetic leg and began working with the physical therapist. Once this happened, he resumed his activities on the block and began feeling hopeful again about his prospects for an appeal to his conviction. In Emily Cohen’s (2015) work on military amputees and surgeons in Colombia, she describes amputation and the technological intervention of a prosthesis as holding the promise of restoring vitality and nationalism, to repair both the body and the relationship

to the state. Ironically, this restoration relies on the production of suffering through disciplining the pain that amputees feel during and post-surgery, reminding us of the social and physical suffering that accompanies not just the original trauma, but also the subsequent medical intervention. The political promise of the prosthetic evoked in Cohen's work is mirrored in the feminist perspective of the human-technology hybrid "cyborg" offered by Donna Haraway. Haraway argues that inhabiting the duality of the "cyborg" – an integration of biology and technology – allows us to more effectively navigate the demands of a technologically-mediated society and social patriarchy. This kind of cyborg politics, she suggests, may be more productive than politics grounded in particular identity positions that are based on dichotomies like mind-body and male-female. She writes, "Cyborg imagery can suggest a way out of the maze of dualisms in which we have explained our bodies and our tools to ourselves" (Haraway 1991:181).

For Eddie, his multiple prostheses allowed this kind of mobility – through politics, social conditions, and the material space of the prison – to confront whatever additional tests the future may have had in store for him. He felt newly enabled, while also being reminded of and carrying the physical evidence of the losses he had endured. For these reasons Eddie's experience may contradict some of Haraway's optimism that cyborg imagery – and by implication the prosthetic – provides a way out of the dualisms and contradictions of gendered and other identity positions. While Eddie was able to redefine his conception of masculinity and refute the links between masculinity and criminality that were created through his gang involvement and that were stereotypically imputed onto him by the prison staff, he also ironically relied on those stereotypes in order to juxtapose himself against them. When discussing his hopes for a commutation of his sentence, he mentioned how he hoped that he would receive time served and that a judge might see "what's left" of him and conclude that he posed no threat to society: "A judge just has to look at me. I'm old now, and only one leg. What am I gonna do? I can't run around committing crimes on one leg!" Evoking how he had literally lost part of himself and the inability to fulfill even the criminal caricature that the state had of him, he embodied not only contradictions in masculinity, but also the sociomedical complexity of his injuries. He evidences the much broader ways in which his amputation changed his

ability to interact in the world, altering his sense of self and the ways he could be viewed by state.

Lest Eddie's attempts at recuperating masculinity be read as a triumph of the rehabilitative goals of incarceration – as though imprisonment afforded him the opportunities to build masculine and paternal relationships with his family and other incarcerated men that were built on support rather than violence – viewing these kinds of relationships through the lens of the prosthesis demonstrates how they were able to persist (or even thrive at times) despite, not because of, the circumstances of his incarceration. Only through loss, pain, and suffering was Eddie able to move forward, and only with scars and phantom pains could he continue to endure. All masculinities are prostheses, allowing those who embody and practice them to adapt and move, to negotiate social circumstances, while still containing evidence of injury and trauma.

Eddie was made to inhabit the contradictions and dichotomies that the prosthetic represents. He lived in a state of “what if.” What if Eddie had not been incarcerated and the hardship had not put strains on his family? Would he be a worse father or a better one? Would the masculine connections that he built as a young man in a gang have transformed into violence and instability or mutual support and recognition? Finally, a question that often guides the public's thoughts on the kind and quality of healthcare that inmates receive compared to the healthcare received in communities: What if Eddie had not been incarcerated? Would he have lost his leg? These questions bring us full circle to considering the question Troy posed of rehabilitation and care in state custody presented at the beginning of this chapter. It frequently seemed obvious to both inmates and staff that Graterford did not hold the capacity to correct or rehabilitate, but that in the best circumstances could provide an opportunity or encouragement for positive change in inmates' lives. What I have shown here is that those opportunities for change and moments of care or recognition take place within a much broader context of loss and losses in which healthcare services took part.

¹ In fact, at the time writing this, Troy remains incarcerated and has just surpassed 5 years behind bars.

² Classification took place at another state facility, and included placing inmates at a “custody level” (1-5) which “[r]efers to the degree of staff supervision and control necessary to monitor the behavior of an inmate” and was determined by the Pennsylvania Additive Correctional Tool (PACT), “an objective, behavior-driven classification assessment based on a ‘just-deserts’ philosophy” (*A Handbook for the Family and Friends of Pennsylvania Department of Corrections Prison Inmates*. September 2013: 9). Inmates were then transferred to serve the remainder of their sentence at a prison with the corresponding custody level.

³ “Personal liberty is so dear to all men, that the loss of it, for an indefinite time, is a punishment so severe, that death has often been preferred to it” (Rush 1787:10).

“The death of a malefactor is not so efficacious a method of deterring from wickedness, as the example continually remaining, of a man who is deprived of his liberty...” (, 1792:12).

⁴ Here Troy was referring to how other inmates, especially those serving life, and staff might instigate fights and provoke other misconducts in order to lengthen the sentence for an inmate who is serving less time. Troy described this kind of behavior as a “set up, all the way.” Of inmates getting on other inmates cases, he said:

They don’t have nothin’ to lose, that’s all that is. That’s the only thing [they] got against me. I’m not tryin’ to max this out. I’ve already been down a while already. You done probably just came in from county, just took a [plea] deal. I’m not tryin, you know... I’m not tryin’ to max out. I got kids and all that, ain’t nobody tryin’ to max out and stay here. Versus you who don’t have anything. What, are you waiting on an appeal? An appeal’s gonna take about ten years. You still gonna be thrown away.

Guards, Troy figured, were in it for control and power, serving a system that profited off the prolonged incarceration of inmates:

Ok here we go.... There’s 8 phones on the block. There’s 400 people on the block with 8 phones. You mean to tell me you don’t think there’s gonna be a fight between these 8 phones and 400 people? I believe somebody set that system up, so we can fight, cuz there’s no way. Four hundred people with 8 phones on the block? Nuh uh. Then you let them out all at one time. I believe that’s just, that’s what I just believe is being cheap. They didn’t wanna you know, fix, then some of the phones doesn’t work. Yeah, they just being cheap. That’s all I believe that gain from. Saves ‘em money. Saves ‘em money. Cuz each one of us, you know, the longer we stay we are a commodity of the state. It’s money for each time one of us stays here, so why not let them max and slug it out? ... Get more money.

⁵ R. W. Connell defines hegemonic masculinity as “the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women”(2005:77).

⁶ See for example Hassine (2011), who also writes about Graterford specifically, and Sabo et al.’s anthology of prison masculinities (2001). They demonstrate how sex with inmates can be exchanged for protection, material goods, and privileges like phone time as well as leveraged for positional power within prison inmate hierarchies. These notions and the proscriptions on sex dovetail with the notion that sex in the prison context cannot be about the fulfillment of sexual desire or interpersonal connection and is instead always driven by power and manipulation.

⁷ “Engaging in sexual acts with others or sodomy” is a Class I misconduct, which requires an internal disciplinary hearing process where guilt is determined based on the preponderance of the evidence. If found guilty, an inmate is removed from his job assignment and may also face time in disciplinary custody, loss of privileges, and fines (Pennsylvania Department of Corrections Policy DC-ADM 801, “Inmate Discipline”).

⁸ *Farmer v. Brennan*, 511 US 825 [1994]. In *Farmer*, an inmate who identified as a transgender woman had her Eighth Amendment protection against cruel and unusual punishment upheld in response to the danger of placing her in the prison’s general population.

⁹ During the period of my fieldwork, in fact, a male correctional officer at Graterford was convicted of sexually assaulting an inmate with the threat of revoking his visitations (Carl Hessler, “Ex-Graterford Guard Convicted of Institutional Sex Assault of Inmate,” *Delaware County Times*, March 10, 2016, <http://www.delcotimes.com/article/DC/20160310/NEWS/160319977>). This was only one incident that took place in 2012. In 2015, there were 77 total allegations of sexual misconduct on the part of inmates and staff at Graterford alone and over 1,200 across the state of Pennsylvania (“Prison Rape Elimination Act Annual Report” Pennsylvania Department of Corrections, 2015). A very small number of the total allegations are ever substantiated through internal investigations, which is both heartening that silence around this issue is not encouraged and disheartening that few allegations can meet the burden of proof in order to be substantiated and that concerns about misconduct are so ubiquitous.

¹⁰ Romantic relationships between doctors and patients outside of prison breach professional codes of ethics set forth by the American Medical Association and other bodies for similar reasons about the nature of consent and power dynamics. However, such relationships are not considered illegal and do not result in a scenario in which interpersonal relations between doctors and patients writ large are so drastically affected by this restriction.

¹¹ “There shall be no fraternization or private relationship of staff with inmates, parolees, or members of their families. This includes, but is not limited to, trading, bartering or receiving gifts, money, and favors from the inmate or the inmate’s friends, relatives or representative. Moreover, employees are not to deliver gifts or money to inmates’ friends, relatives, or representatives.” (Section B “Specific Rules and Regulations,” PA Department of Corrections Code of Ethics).

¹² While PREA was passed as law, its provisions are not yet technically legally binding (see Jenness and Smyth 2011). Agencies like the American Correctional Association (ACA) have partnered with the Department of Justice to implement PREA’s requirements. At Graterford, 100% participation in the PREA information session was required for the institution to receive its optional accreditation from the ACA, which, according to the agency, offers benefits such as “enhanced public perception” and “defense against litigation” (“Health Care Accreditation,” American Correctional Association, accessed August 27, 2016,

http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Healthcare/Health_Accreditation/ACA_Member/Healthcare_Professional_Interest_Section/HC_AccreditationHome.aspx?hkey=5b21416b-fee4-47fd-9eed-2597879e7076).

¹³ In another part of the session, the presenter broached the issue of placing victims or potential victims of sexual violence in “protective custody” (i.e. solitary confinement) by saying, “We don’t do that as a blanket recommendation anymore. It’s up to the discretion of the staff.” Her response goes against some of the rigid interpretations of *Farmer v. Brennan*, which claimed that the inmate Farmer was knowingly put in harm when placed in the general population, and staff was therefore deliberately indifferent to her suffering. The speaker’s remark that placement in protective custody was up to the discretion of the staff demonstrates that institutions have ultimate control in the administration of prisons if they can be loosely understood under outside

the legal construct of deliberate indifference, which comes out clearly in my discussion of these legal standards in Chapter 1. More to the point in this context, the comment also indicates that there is an acknowledgment that sexuality, gender, and sexual violence are more complicated than the law can allow for by just identifying biological sex and sexual orientation and determining whether or not protective custody is appropriate.

¹⁴ In the first volume of Foucault's *History of Sexuality*, he describes how discourse around sex simultaneously became a truth-seeking endeavor backed by expert knowledge and a repressive endeavor. Restricting talk of sex paradoxically promulgated the scope of what talk of sex could be used for within relations of power-knowledge (Foucault 1978).

¹⁵ Reviewing footage from surveillance cameras was often requested and often denied in inmates' retellings of disciplinary hearings. From discussions with other staff members, I was led to believe that cameras were often broken and that security staff would usually only review live streams. As a result, cameras rarely recorded events so that they could be reviewed later, except in the case of handheld video cameras. Ironically, the technology that was meant to monitor inmates and ensure their behavior could not be relied upon to prove that they had followed the rules or that staff members had broken them, though sometimes staff members did refer to the presence of cameras as a reason why they might restrain themselves and not use excessive force as retaliation.

¹⁶ Because methadone was among the only available opioids available for treating pain, Roger was receiving methadone as his source of pain management for his lymphoma. Methadone, typically used for chronic treatment of opiate addiction, was seen on his chart when he arrived at the dispensary, and because of the delirium and difficulty speaking that Roger was experiencing, they assumed he had been hoarding his methadone and took a larger dose to get high. They administered a drug, naloxone, to reverse the effects of the presumed overdose, which was noted in his chart. The cavity search and catheter placement Roger claims took place outside the prison at the outside hospital. The cavity search would have been performed to see if he had been storing drugs in his rectum, and the catheter would have likely been placed to do a urine drug screen. No record of the procedures or his consent to them appeared in the hospital's notes forwarded to the prison, nor did they appear in Roger's subsequent sick call visits when he reported continued bleeding from his rectum and urethra as a result of them.

¹⁷ Incidentally, this affected how I was able to conduct fieldwork as well, especially given that anthropology utilizes a methodology that requires building interpersonal relationships and establishing trust and interdependence. The restrictions around inmate contact made it illogical and threatening for inmates to get in touch with me (and for me to want inmates to get in touch with me) outside of our interactions within the prison, for which there was the same expectation of physical and emotional distance. In fact, an officer chastised me one day when a man I hadn't seen in a while was walking through the medical unit, and I greeted him with a handshake and a hug. I was told, "I know you want to seem like a good guy, but you can't be doing that. You can't be touching inmates like that. I'll pretend like I didn't see that, but don't let it happen again." It was also extremely difficult to follow up with people when they were transferred or released into a form of community custody because we were not able to exchange personal contact information prior to his release.

¹⁸ In 2013-2014, Pennsylvania's female inmate population increased 3.6 percent from 2,662 to 2,758, more than 2.5 times the increase in female inmates seen on a national level. For comparison, the male inmate population in Pennsylvania went from 48,760 to 47,936 (Carson 2015).

¹⁹ Megan Comfort provides an ethnographic understanding of how the prison is relied upon to recreate domestic relations and the performance of gendered domestic labor (2002/2008). See also Ruth Gilmore's participant-analysis of the gendered work of prison activism (1999).

²⁰ Pennsylvania was slow to integrate female correctional staff into their male facilities. Along with Alaska, Texas, and Utah, Pennsylvania was one of the last four states to employ female correctional officers in all-male institutions (Josi and Sechrest 1998:131).

²¹ Earlier in our conversation we had discussed how Dr. Keller preferred to avoid knowing his patient's criminal charges and "legal issues," attempting instead to focus only on their medical needs as a way of ostensibly remaining impartial.

²² German sociologist Max Weber defines the modern archetype of bureaucracy as an administrative structure that controls completely via thoroughly rational-legal administration and authority, and "does not establish a relationship to a *person*," but is "devoted to impersonal and functional purposes" (Weber 1946:199).

²³ See Berlant (2007) for a discussion of "slow death" in the opposite context of obesity and eating unhealthy foods as an expression of what she calls "lateral agency" in the face of the crushing biopolitical administration of life.

²⁴ This facility was typically referenced as a "heavily guarded fortress," "more nursing home than prison," and "the Shangri-La of the DOC." Apropos of the discussion on gendered labor above, the female Correctional Health Care Administrator who helped facilitate transfers there was seen by some of the staff at Graterford who tried to work with her to get inmates sent there as a "power hungry gatekeeper."

²⁵ The research study, conducted by the Brain Injury Association of Pennsylvania with a \$250,000 grant from the Pennsylvania Commission on Crime and Delinquency was examining the links between traumatic brain injury – including such injuries that may not have gained clinical attention – and changes in personality including an increased tendency toward aggressive behavior and criminal activity, and how these impairments limited inmates' abilities to adhere to institutional norms, meet parole requirements, and survive in the community after release. The topic of brain injury and aggression was gaining popularity in neuroscience investigations, especially as a possible explanatory model for crime, reviving old connections between biological science, race, and criminology. This thinking has even been applied to the infamous OJ Simpson murder case. Some claim that subclinical brain injuries he had endured from playing football resulted in chronic traumatic encephalopathy, raising questions about the role brain injury may have had in the murder case (See, for example http://www.slate.com/articles/news_and_politics/chatterbox/2007/09/squeezing_ojs_brain.html).

²⁶ Non-steroidal anti-inflammatory drugs are platelet inhibitors and cause damage to the gastroduodenal surface. They are both causative and exacerbating agents for gastric ulcers and gastrointestinal bleeding and should therefore be avoided in the case of presumptive gastrointestinal bleeding from an unknown cause.

²⁷ It was unclear to me at the time if she knew that it did not exist, or if she thought that it did because other doctors had brought up in different contexts continuing the use of opioids on patients with confirmed conditions.

²⁸ Ultram (generic name tramadol) is an opioid pain reliever.

²⁹ Neurontin (generic name gabapentin) is a non-opioid medication used to treat nerve pain. It was highly suspected for abuse because of its sedative effects, placing it in a class of medications providers at Graterford called "sleepers" that were supposedly desirable to inmates who wanted to sedate themselves.

³⁰ Elavil (amitriptyline) is in a class of antidepressant medications used to treat major depression and nerve pain. Keppra (levetiracetam) is an anticonvulsant used to treat seizures.

³¹ Natalie Kostelni, "Graterford State Prison Farm Closed By Officials After 70 Years," *The Morning Call*, June 16, 1999, http://articles.mcall.com/1999-06-16/news/3246876_1_mike-lukens-farms-two-other-prisons

³² The typical process for people entering prison with medical devices was to have them mailed in and screened. Some were banned outright or inmates were required to purchase or obtain prison-issued devices, especially if a condition was diagnosed during their incarceration. Many, though, had to be mailed into the prison and examined and approved by security staff. The policies also seemed to change frequently and the providers often consulted one another as to what the appropriate course of action was.

³³ See Karandinos et al. (2014) for a description of these kinds of reciprocal obligations of gang violence in contemporary North Philadelphia that draws on E.P. Thompson, James Scott, and Marcel Mauss to refer to a "moral economy of violence." The authors describe how kin and gender roles augment this moral economy and how it works to drive an illegal drug economy that replaced industrial city jobs.

³⁴ In the context of global flows (and selective uptake) of food, capital, and culture in India, see Solomon (2016) for a description of how diabetes therapy creates different "lines" that patients follow, some of which stop or pass through amputation.

³⁵ See also Sarah Jain's work on psychoanalysis and prostheses, where she critiques tropes of prosthetic devices that herald them as surmounting the biological limits of the body with technology and discusses instead the double nature of the prosthetic as both enabling and disabling (Jain 1999).

Chapter 4 – Anti-Vax in Supermax

Y'all stupid to take that shot, yo!

- RHU Inmate

At the height of the West African Ebola epidemic in October 2014 and a couple of weeks after the first reported cases of the disease in the United States, I accompanied the healthcare staff at Graterford for their flu vaccine clinic. The circumstance of the pandemic spread of one of the most quickly spreading and deadliest viruses surrounding the implementation of a specific medical intervention for another infectious disease brought some of the everyday politics of engaging with healthcare services, like suspicions of experimentation and fears of illness, to a head in drastic ways. This chapter conveys my experience as a participant-observer in the clinic during one of the few instances I was directly involved in the care of inmates as a medical trainee. The ethnographic journey from the administration of the clinic in the general population to performing injections in the RHU provides an interlude linking the themes and content of the adjoining chapters as well as an opportunity to highlight healthcare delivery in “the hole.”

Treatment for acute and infectious disease processes and more chronic or non-infectious illness involved differences in providers' suspicion of inmate malingering and thoughts about individual deservingness and responsibility. Preventative measures like vaccines and the scientific validity of a diagnostic laboratory result helped erase suspicion around the veracity of a medical claim, but cast different aspersions about cleanliness and lifestyle (e.g. lack of hygiene and unprotected sex or injection drug use). When inmates were screened for sexually transmitted infections on intake, they often only saw a healthcare provider when they were called to the medical unit after someone flagged their positive test result, where they were then instructed to follow a medication regimen and dismissed. After such encounters, providers would frequently make comments like, “Who knows how many women he gave that to! Or what kind of nasty

sex they were having!” or “Who would have sex with *that?*” casting inmates as unclean transmission vehicles for disease. The sentiment behind these comments was particularly salient when discussing inmates who were housed in the RHU, where they lived in close, often unsanitary quarters. We have already seen how the right to healthcare differs in theory and practice, and how care elicits skepticism among inmates placed in a position of vulnerability when it is combined with the custodial functions of the prison, the emasculation of incarceration, and the extraction of profit. These issues collide and are consolidated in the setting of the flu clinic, where inmates engaged with healthcare providers as the objects of a specific medical intervention. This example will in turn provide a starting point to delve further into the political dimensions of care and the implications of care and suffering for justice in Chapter 5.

This excursion conveys how care and custody are constitutive of one another, illuminating in specific moments how some of the structural conditions and interpersonal dynamics in the prison simultaneously open up and foreclose the capacity for medicine to provide supportive care. How can acts of care – preventative vaccination measures to support health – be understood in an environment that fosters suspicion, isolation, and subjugation? What do inmates’ responses to that care illustrate about care’s effects and potentials? The flu clinic conveys how the prison was a crucible, transforming inmates’ anxieties about care, identity, and health security during confinement into both their decisions about their own healthcare as well as transgressive acts around care that both critiqued power and mobilized their identity as wards of the state. In political acts of acceptance and refusal of medical intervention, inmates used their own insider knowledge of prison life, the threat of disease, and the dehumanizing aspects of care and reflected it back at those in control in order to chip away at medical and carceral legitimacy through the metaphors of toxicity, emasculation, and objectification.

The flu clinic also offers a glimpse at the cognitive and material work that was done to maintain the prison clinic as an authoritative space, ensconced in the staff’s literal and discursive silence regarding the complications of providing adequate care in this context. The words and actions of the inmates in the general population and the RHU – despite being cast as manipulative, incorrect, conspiratorial, and sometimes vulgar –

break this silence and expose the providers' anxieties and vulnerabilities as well as the inmates' fragility as wards of the state. In this setting, the configurations of space and power imparted by the institution complicate something as seemingly simple and straightforward as administering a vaccine investing it with authority over the body and life, augmenting inmates' senses of isolation and captivity. The deeply felt ambiguities and ambivalences of care during incarceration are revealed here where the broader conditions of state custody collectively manifest in inmates' interactions with state and medical power.

In many ways, vaccine and infectious disease eradication programs are paragons of biopolitics, linking state and medical governance. These programs embody the central paradox of biopower, offering a productive and life-fostering protection against disease on the population level, yet doing so in concerted, state-sponsored efforts that undermine local sovereignty, establish social hierarchies based on contamination, and in some cases derive profit from a healthy labor force. As public health projects, vaccination and infectious disease programs have been tied to imperialism, colonialism, and domination both domestically within the United States as well as internationally.¹ In this context, popular responses to vaccination can take on different slants in settings where foreign aid and foreign governments control them versus settings in economically advantaged countries where they are administered by domestic governments alone. Specifically, anxieties around experimentation and state control in the former are often replaced with balancing population-level statistics and personal harm, risk, and toxicity in the latter, but always involve the overlay of medical technology onto personal and social worlds (Fairhead and Leach 2007). The prison uniquely combines heavy state influence and control with this more general and undefined risk environment of the United States, where social and environmental uncertainties are displaced onto medical intervention (Kaufman 2010). In this way, the flu vaccine clinic highlights the ways that submission to care was also submission to authority, and how it involved relinquishing forms of bodily freedom as well as the expression of personal and collective suffering.

* * *

The vaccine clinic day, organized by Nancy, the methodic British infectious disease nurse who wore her hair short and kept her conversations shorter, was part of a concerted effort to make sure flu cases in the prison were diminished, and the population was not put at risk for developing more serious respiratory infections. The vaccine clinic had been planned weeks in advance, bolstered by the auxiliary subsidy funding lent to infectious diseases,² which additionally often involved more coordinated screening, follow-up, and treatment because of its status as a public health issue. Contrary to the comparatively isolated chronic disease processes incarcerated individuals faced, infectious diseases could be spread not only to other inmates, which would raise the cost and effort to treat them, but also to communities of innocent people. Thus, although infectious disease processes were one of the few instances in which inmates were seen as a collectivity, thus diminishing the isolating effects of incarceration, this collectivity was framed by disease and contagion. Furthermore, infectious processes also structured what kinds of medical claims were possible (i.e. by limiting treatment to access to pharmacotherapy) while also making disease through screening more visible to medical staff.

Nancy scheduled the providers around their usual clinical duties in the morning, placing all the nurses who were not distributing medications or covering emergencies at her disposal. I was also recruited to help; Nancy, who knew that I was a medical student, had taken me aside earlier in the week and told me this was an “all hands on deck” situation and asked me if I could assist during the clinic. I politely told her that I could help out but reminded her that I was there as a researcher and not a medical student, since there were often misunderstandings and confusion about my dual identity and purpose in the clinic. I said that because I didn’t have approval to act in any medical capacity, I was technically not supposed to give any vaccines. Nancy said that was fine, and that I could help out stocking vaccines and syringes and taking inmate information. She asked me to come in earlier than usual, at 7:30am, to help set up and organize the prison’s auditorium, where the clinic would take place in order to accommodate the large flow of inmates.

When I arrived at the prison's auditorium the next day, Nancy escorted me down one of the aisles to the front, where three tables were set up with two providers each to administer the vaccine. At a table down toward the front of the aisle, I joined Claire, the middle-aged white nurse practitioner, and James, an Asian-American physician assistant student completing a community health rotation at the prison who was about my age. We were supposed to check inmate IDs as inmates came in down through the aisle, take their temperatures, and write down their inmate numbers and temperatures on a loose sheet of paper before they went to the front of the auditorium to receive the injection. We were also tasked with distributing an informational pamphlet to anyone who wanted one. The pamphlets, available in English and Spanish, detailed the reasons for getting the vaccine, how it was produced, and side effects including allergic reaction, Guillain-Barré Syndrome,³ and "symptoms commonly mistaken for the flu." On the pamphlet it was written in bold print: "Getting flu from this vaccine is not possible." A separate section of the pamphlet mentioned that the vaccine contained a "very small amount of mercury preservative called thimerosal" that "is not harmful."⁴

The inmates who had responded to the offer of a flu vaccine came in in waves of about 100, block by block, and even though we processed them quickly, it seemed like we were never stopping; as soon as we got through one wave, the next would come through. Claire, James, and I divided the labor so that one of us was taking down inmate numbers and writing temperatures while the other two were taking temperatures, occasionally lagging behind because one or the other thermometer would stop working. We laid the information sheets out on the table next to us in case anyone wanted one. Towards the middle of the session, at around 9:30am, the "jumpsuits" came in from E Block, where all the newly incarcerated men and some returning parole violators were kept before being classified and sent to the institution where they would serve out the remainder of their sentences. They overlapped a bit with the "browns," the general population, also named after their clothing – in this case a brown buttoned shirt and pants. This co-mingling happened often during regular clinical operations despite technically not being allowed for security reasons – the stated rationale for keeping E Block locked down for 23 hours most of the time. The vaccine clinic offered a good

opportunity for me to see the blocks as a group and to see people beyond those who might regularly seek out healthcare.

The men from E Block were younger on average and seemed to be more racially inclusive in their social interactions. White men chatted with Latino and black men and some Latino men talked to a group of older black men. In contrast, the general population stuck mainly within their racial enclaves. Men frequently remarked to me in our general interviews about the crowded and unsanitary living conditions, and how they often made it easier to get sick. I therefore presumed that all the men were there primarily to protect themselves from getting a communicable disease given such an environment. Proportionally, the new inmates from E Block had more representation in the vaccine clinic than did the general population, owing to the fact that these conditions were more pronounced on there, where the overcrowding and lockdown conditions were the worst (second only perhaps to the RHU) and men were only allowed to shower once a week with an occasional change of clothes. On E Block men were also transported around more frequently, exposing them to more people than the more stably housed general population. Providers often discussed the lack of hygiene for most inmates (but especially those on E Block) as if it were a personal characteristic rather than a result of the prison's control over what kinds of hygienic products they could have and how often they could shower and change their clothes. Providers would even sometimes blame many inmates' dermatological conditions (e.g. fungal infections, abscesses, and scabies) on this perceived lack of hygienic practices rather than unhygienic conditions. In support of the idea that conditions and punitive prohibitions contributed more to a lack of hygiene than an inmate's character flaws or lack of civility, many inmates would pocket alcohol swabs that were laid out for diabetic testing in the infirmary, which were typically considered contraband, and use them to clean their faces and other parts of their body. They would also use the reflective surfaces of the metal cabinets in the dispensary to check their appearance or to follow concerning marks or blemishes. Often providers and officers would look the other way when inmates would do these things, but they were also sometimes discouraged from continuing such practices.

A surprising number of people, regardless of their length of stay or which unit they were housed in, brought up the Ebola outbreak at the clinic, asking if the flu vaccine would protect against the disease or if the vaccine itself had Ebola in it. Amidst the volume of all the other conversations going on as inmates waited in the aisle to move forward to the tables where the vaccine was given, I could always hear someone discussing Ebola, and those questions usually made their way over to where we were working. Inmates would say, “You heard about all this Ebola stuff?” “What about that Ebola? Is this gonna give it to us? What are you trying to do here?” “Hey, is this gonna keep us from getting Ebola?” These questions were often then directed at us as medical staff, making us aware of inmates’ attention to the multiple threats to their health and their skepticism about the intent behind holding the clinic given the coincidental pandemic. An inmate would look to Claire for her response and usually make a point of demonstrating his knowledge of this information, referring to news stories about it and starting a discussion of its seriousness, to indicate that they would not be taken advantage of for lack of their broader knowledge of events outside the prison. When they were specifically directed at her, Claire would address the concerns about infection or experimentation with a simple “no” or a response that this vaccine protected against flu and had “nothing to do with Ebola.”

James told me that Lance, the older white physician assistant, had actually joked earlier that we should all tell inmates that we were administering an experimental vaccine against Ebola and that we would give them the vaccine and then expose them to Ebola to see if it works. His joke (whatever the ultimate intent) relied on the fear and infectious threat of Ebola as a precondition for discouraging inmates from taking the vaccine, thus potentially cutting down on the amount of labor involved in the clinic. The clinic was organized on an opt-in basis, so all of the inmates who showed up to the clinic had decided when the officers on the block announced the clinic that they wanted a vaccine, and not many refused after showing up. There were a few, however, who did refuse. A few black men and one Latino man refused to get the vaccine after arriving at the clinic, while standing in the crowd waiting to have us write their number down and take their temperature. The black men cited concerns about being injected with Ebola and not

knowing what else might be in the vaccine. It was unclear whether Lance's joke had started to spread or if this fear was drawn out because of all of the other circulating Ebola-talk. Some said not knowing what was in the vaccine "didn't fly" with them, and they wanted to know what was being put in their bodies.

The Latino man asked for an information sheet to look at the side effects. After reading them, he discussed with another group of inmates that the vaccine could give you flu-like symptoms: "It contains the virus, dude! So you could actually get sick, get the flu, just from takin' the shot!" After this he looked at us and started shaking his head. "Nah. Nope!" he said. "I don't wanna do this! I was gonna get it so I *don't* get sick. I'm not about to get sick because of it!" With that he began to fight his way against the crowd back up the aisle. I called after to him to attempt to discuss his understanding of the vaccine, not really knowing if my goal was to convince him or to understand his decision from an anthropological perspective, but he had made up his mind. He shook his head and waved his hand at me as he continued pushing against the flow of people moving toward our table and stood with the guard at the auditorium entrance waiting to return to the block.

At the end of the general population clinic just before noon, we had signed in approximately 800 inmates and administered as many vaccines. In the afternoon, while regular clinical duties resumed for the rest of the staff after their lunch break, James and I were sent over to deliver the vaccine in the RHU with Ron, a shorter, white male nurse in his 50s who regularly worked in the RHU. The RHU was made up of two blocks, L and J, where inmates were held in high security units on 23-hour-a-day lockdown, sometimes in solitary confinement, but usually two to a cell to accommodate overcrowding. Nancy had pulled James and me aside in the morning and said, "Can you two go with Ron to the RHU to do vaccine clinic there in the afternoon? I hope you don't mind, but we have to do it, and you're the only males I have that can be spared in the afternoon." Men typically performed the work of healthcare services in the RHU. It was presumed that men would make things run more smoothly because they would not have to respond as much to objectification and their presence might prevent or preempt any verbal outbursts or violence.

The RHU housed inmates that providers referred to as “capital cases” in J Block, and inmates who were there in disciplinary or protective custody, or else in transit without another place to be housed in L Block. As such, its residents were frequently seen as the “worst of the worst” – men who would stereotypically have angry outbursts that bordered on sociopathic – even though the majority of those on L Block were housed there temporarily and were therefore part of the population of patients that providers saw every day with limited supervision and without restraints or physical isolation and segregation. In fact, with the exception of some men who were only at Graterford while in transit to another facility, all of the inmates who participated in my research had spent some amount of time in the RHU for disciplinary reasons. The denotations that were used to refer to RHU inmates’ legal cases and their behavior marked the population racially and psychologically. Despite the fact that most of the population went back and forth between the general population and the RHU, when men came to inhabit the space of the RHU they also inhabited the catch-all label of pathological aggression. In the case of J Block, inmates were kept there permanently and permanently embodied the label and stigma of their criminal convictions as “capital cases.” At a time when there was increased attention paid to the labels that inmates were given, and the state itself began its rejection of the term “offender” (especially for former inmates returning to their communities)⁵ it was telling that the label of “capital case” remained with this population, whose members were seen as the literal embodiment of their crimes.

Providers were often reluctant to do regular sick call there, where they would have to travel cell to cell to see inmate who issued a sick call request, yet they were legally obliged to do so every day of the year. It was frequently avoided or shirked for other clinical duties, and some providers, like Dede, would even attempt to trade their assignments to avoid going there. When I asked her why she did not like that assignment, she replied, “The population. They’re very rude, obnoxious. They just get me upset all the time. So, just... there is no order. Cause they’re behind the bars, you’re like screaming, and they’re screaming, and the communication is just poor, and you can’t really assess because they’re not outside the cell, so... that is a problem. There is a big barrier with that population.” During these visits providers would travel to each cell,

sometimes accompanied by an officer, to see an inmate who had submitted a sick call request (sometimes for a specific medical issue and frequently for a renewal of medications). Brief physical exams were sometimes attempted through the cell door, but providers would have to make difficult decisions about whether to pursue “watchful waiting” for a medical issue or to have the inmate be shackled and escorted to the dispensary for a full exam. Dede was frustrated by her inability to do a thorough exam or even just have the officer escort the inmate to the assessment room where they were searched before and after leaving the unit or accepting lawyer visits, which officers were reluctant to do. She was afraid of not being able to adequately address the inmates’ medical needs, but also fundamentally concerned about being liable for not doing a complete medical exam in the event of something serious: “No one will let you get away with not doing a physical exam if someone has a real complaint! They will ask for the documentation, and there’s nothing!”

One of my earliest trips to the RHU with Dede reflected how this facility augmented the dynamics of gender, sexuality, and vulnerability that dictated care and security in the prison and imputed aggression and deviance onto inmates. I was with Dede and Tonya, another female nurse practitioner, on a regular sick call visit that they were legally required to do daily. Dede was new then and Tonya was taking her around to help introduce her to the facility. The white, male officer there had stopped us before entering the units, and told us that it would probably be “ok” that day for us to go through; things had been quiet recently because they had increased use of “the chair,” a device where inmates were seated and strapped down to limit mobility and left for hours at a time. He said, “Sometimes you have to use more aggressive measures like OC [pepper spray] or electricity [tasers]. These guys are strong. All they do is work out. It’ll sometimes take eight officers to restrain one inmate.” He then moved on to talking about how Dede’s looks and her race in particular might stir the inmates: “You, too. I mean, a new, attractive black woman in here is guaranteed to get more attention.” Tonya added that she would have inmates put in sick call for her “just so that they could masturbate.” The guard then looked over at me, glanced up and down, and said, “For you, it will be more a size issue. I don’t mean no offense, but these guys are jacked.” He then rounded

out his thought and consolidated these themes in the context of care provision: “But you guys are doctors, so of course they’re gonna try to get something from you and try to manipulate you...” At that moment some of the inmates started calling out, though it wasn’t possible to hear exactly what was being said. The guard responded, “See, they see that we’re talking right now, and they’re gonna try to take control of the situation.”

On the flu clinic day, James and I headed over to the RHU with Ron, making the long walk across the campus, behind the kitchen and industrial shops through the “gauntlet,” a long road lined on both sides by the two RHU blocks and the individual chain-link cages where RHU inmates had their yard time. It was named the gauntlet because, if the inmates were in the yard when you were walking past, they would almost certainly yell out at you, making offensive and typically vulgar comments. In fact, most of the sick call visits were done first thing in the morning before inmates would be out in the yard so that providers could avoid ridicule. Another time when I accompanied Lance to sick call in the RHU in the late morning, having missed the window of opportunity early in the morning, inmates yelled at us as we walked the gauntlet on the way in and out of J Block. Lance, who was taller than I and had grey hair and a mustache, but had a similar build to me and was also white, walked just beside me. The inmates began shouting that Lance was my “sugar daddy,” yelling a few insults about “those two homos” and poked at my appearance, drawing on tropes of whiteness calling me “Justin Bieber” and saying, “Oh you know he skateboards! You want some weed, skateboarder? I got somebody outside could hook you up!”

There were few inmates outside on this crisp October afternoon, affording some luxury in passing through the gauntlet without being taunted. The flu clinic started on J Block, where the “capital cases” were held. The building was much older and itself surrounded by a chain-link perimeter topped with razor wire – a prison within a prison – with a gate section of the fence on wheels near the outer stone wall that surrounded the campus proper. The security camera mounted at the corner of the gate caught our presence, and the gate slowly rolled open. Other interactions between providers and inmates in the RHU involved trade offs stemming from some of the issues mentioned above in deciding whether or not a specific medical issue warranted further evaluation

and the expending of resources. These interactions were frequently charged with different expectations for what kinds of examination and treatment inmates could get and what was seen as logistically possible on the unit. Everyone was frequently hostile during these encounters; inmates were unsatisfied with the amount of attention they were given, and providers were frustrated that inmates would lash out. In contrast this trip felt as though it would be more straightforward. We were there to deliver a specific service that inmates could either accept or refuse. What occurred demonstrates how even clinical interaction that had more clear-cut expectations and procedures were still able to magnify the tensions involved in care delivery in this context. Indeed, if the general population clinic had magnified and transformed anxieties about custody and contagion, the RHU – where the structural and spatial concentration of power and vulnerability – did so exponentially because the stakes were exponentially higher.

After we went through the moving chain link fence and buzzed into the block, signed in, and prepared our cart, which had all the vaccine supplies and a computer to scan the inmates' IDs, we made our way through the individual corridors. In contrast to the general population blocks, where there was a central main corridor the length of a football field with each block branching off to one side as long, two-tiered hallways, this block had a central security station with rows of cells emanating from it like wheel spokes, each one blocked off by another locked, barred door. This was one of the few places on the prison's campus that resembled the standard panopticon design heralded in the 18th century.

Because many of the inmates on J block were death row inmates, they were in cells alone.⁶ As with general sick call, they stayed in their cells as we rotated around to administer the vaccine. Many men had sheets hanging up, covering most of the bars to maintain a semblance of privacy. They came out from under the sheets, out of the darkness inside their cells to get shots, many in their underwear or shirtless. Many men had hard plastic "mirrors" with reflective coatings propped up on the bars so they could see fellow inmates' faces and read lips to carry on conversations. James volunteered to give the vaccines here, while Ron (the only one with log in credentials) operated the

computer, and I took the inmates' temperatures, wrote them down, and handed James anything that he needed as we made our way down the corridors.

As we entered the first corridor of about ten cells, talk of Ebola started immediately. Inmates would shout out from their cells either to other inmates directly or to no one in particular. They only spoke to us when we were directly in front of their cells. The men asked if there were any cases of Ebola in Pennsylvania, mentioning the cases in New York and Texas, generally demonstrating that they had kept up with the news on the epidemic and remarking at the coincidence of the flu vaccine with this broader global health threat. After asking if there were any cases in Pennsylvania, one inmate yelled out, "If there were, you know it would be in the prison first!" highlighting conceptions of the prison as a hotbed of disease – a ground zero for the development of health threats that might spill over into communities. They then moved on to raising the same concerns that were coming up in the general population clinic, asking if the vaccine would protect against Ebola and if it contained the Ebola virus. A few inmates claimed that the timing of the clinic was too suspicious, and the injection must contain Ebola for experimentation purposes: "Y'all stupid to take that shot, yo! They got Ebola everywhere and they got to know more about it, so they gonna give it to you so they can learn more before it starts spreading up in America!" Before any of this had even started, Ron instructed James to draw the needles up in front of the inmates, or else they might not believe that it was the flu vaccine: "Show it to 'em, do it in front of 'em. They're likely to ask anyway, and this way shows 'em you've got nothing to hide."

Being an older cellblock, most of the cells there had old-fashioned bars instead of sliding metal doors. Even though most of the cells had bars through which the shot could be given, most were done through the "wicket," the slot where inmates' meals were passed through, both because it standardized the routine of administration and presumably to limit contact with inmates as much as possible. The rationale of limiting the space of care first to the cell to avoid altercations in transporting the inmate to assessment, then further confining it to the small 4-inch by 15-inch rectangle in the cell door, and then distanced still from that vestigial point of interaction was justified under the pervasive security mandate. The first time we reached a cell with a metal door, I bent

down and put my face on the level of the wicket to take the inmate's temperature, so that I could see what I was doing and so that the inmate could see me. Afterward, the guard accompanying us pulled me aside and told me quietly, "You can't do that on this unit. Not unless you want a face full of shit." The inmates picked up on the fact that giving vaccines through the wicket was unnecessary (at least in the presence of bars), inappropriate, and dehumanizing, vocalizing their critiques of what they were considering incompetence. Knowing that nothing they said would actually change what we were doing, a few yelled out simply to be heard, echoing Dede's concern: "You can't take us to assessment?" "Why don't you take us to assessment to do this? You can't be giving vaccines in here!" "It's unsanitary here! You know for a fact that there's feces and urine all up in this jawn,⁷ and you're giving us needles?!"

The threat of attack or acting that accompanied every interaction with or movement of the inmates also guided the avoidance of additional labor on the part of the correctional officers, perpetuating dehumanization as the byproduct of security. Dede, in one of the few moments where a provider engaged in critical systemic appraisal that I witnessed, had actually advocated to have guards transfer inmates to the assessment room in the RHU so that more thorough physical exams could be done during routine sick call trips, eliminating the need to defer the exam or perform a rudimentary exam through the bars or wicket. She, with the support of the medical director, framed the request in terms understandable to the prison administration – that the practice opened them up to liability because the medical staff could not do a proper exam under those conditions. The request never came to fruition, however, with the administration citing safety and security as a catchall logic. The only alternative they said, which created even more staffing and labor problems, would be to have every inmate who needed to be examined put into jumpsuits, shackled at the hands and feet, and transported to the dispensary of the medical unit as they do in the case of emergencies – a process that from an institutional perspective elicits the threat of inmate attack and violence during every part of the sequence. Framing the pushback under the umbrella of security bolstered its legitimacy, but also transformed an issue about labor and contact with inmates into an issue about security, making it such that nothing was outside the security mandate. Security was used to further dehumanize

and isolate inmates as the rationale for anything from limiting interactions with healthcare providers, ignoring cries for help, to actually punishing inmates for seeking medical attention.

One of the last corridors we went down was especially boisterous; inmates were carrying on conversations with us and other inmates, yelling across the corridor not only about Ebola and inappropriate medical practices, but also about drug use. One man yelled from down the hall that he wanted us to give him some of our needles, both to stash for himself and so he could more accurately administer the vaccine to himself, thinking it was given intravenously. He commented that his veins were scarred from years of dope use, so we would have a harder time than he would administering it intravenously, building on the earlier comments about our incompetence. Even though there were white and black inmates on this block, all talking openly about their history of dope use and their comfort with needles, only the black men expressed wariness about the vaccine itself. Some of them, typically the older ones, ended up refusing and advised the others to do the same. Some of the white men who had not planned on getting the vaccine jokingly asked for heroin instead. Ron replied to these requests, saying, “Oh shit! I left the heroin in the other cart!” They got a kick out of this response, and the whole corridor erupted in laughter. Still provoking him, they asked for his laptop so they could watch porn: “You got porn on that thing? Can you leave that with me for a bit?” Ron said he wished he did, but that he would not get any work done if there were porn on his work computer.

In contrast to many of the concerns about Ebola and suspicions of experimentation, which rarely elicited responses or corrections, Ron’s engagement with this kind of salacious and taboo joking demonstrated both that he was not completely shut off and bothered by the comments and that he was in on the joke, an attempt to establish some sort of rapport. The result was that the inmates became energized and even more vocal. One of the men a few cells down from us started asking other inmates what he needed to do about his counselor, who had “done homosexual stuff” to him. On occasion when officers, providers, or other staff would come through the corridors of the RHU, inmates would shout across, asking other inmates about the processes for filing medical grievances, getting medical paperwork, or even the process to get a phone call or see a

counselor. The mention of porn in the context of a medical presence prompted this man to seek similar guidance: “You medical... Do I need y’all to do a rape exam for me?” He and the inmates in all the surrounding cells screamed in laughter at this, and Ron’s only response was, “This is flu vaccine. We’re not dealing with that.” Other inmates echoed Ron’s dismissal, “Yo! You need to talk to somebody else about that. They can’t do nothing ‘bout that here!” When I approached his cell and got ready to take his temperature, he asked if I was going to take it anally. He mocked how I repeated the request to take an inmate’s temperature at every cell, saying it in a high-pitched voice while making flamboyant gestures and laughing, and then bent over when I stood in front of his cell, looking at me over his shoulder with his hands on the waistband of his prison uniform ready to pull his pants down. His joke left me unsettled given his earlier comments about his alleged rape. Not knowing exactly how to react, I rolled my eyes and forced a smirk of acknowledgment, but redirected him, saying, “Come on, now...” He popped upright again and jerked around, saying, “Psh! I don’t want that! Haha!” A chorus of inmates then echoed throughout the corridor: “He do! Yeah, he do!”

The inmates’ comments about medical experimentation, criticisms of the vaccine practice, and mockery over drug use, sexual orientation/masculinity, and sexual violence, can all be understood as a way of creating an environment of shared responsibility and vulnerability. As inmates project their experiences through these performances, they charge providers with the responsibility to respond in the form of recognizing those experiences and providing adequate care in kind. Despite being about ostensibly different things – fears and anxieties surrounding inmates’ vulnerability to harm from staff through inappropriate care, infection, medical neglect, and sexual violence, plus vocalizing the absent pleasures of pornography and heroin – all of the comments were meant to redirect the denigration and humiliation inmates experience daily in the RHU toward us in order to make us feel embarrassed and vulnerable. As Lorna Rhodes writes of the practice of “throwing” – the slinging of bodily fluids at staff that I was warned of – at a supermax facility in Washington state: “The prisoner who sees himself defined as a piece of shit hurls into the faces of his keepers the very aspect of himself that most intensely represents his contaminated status in their eyes. He spreads to them a kind of contagion,

not only by contaminating them with ‘him’ but by making them, at least momentarily, disgusting themselves” (2004:45). While incidents of throwing also happened here,⁸ I suggest that inmates’ remarks and charges against their care during this clinic were also motivated by a similar desire. These comments and actions simultaneously expressed their fear, vulnerability, emasculation, and victimization while also imposing these characteristics onto the correctional and medical staff who were partially responsible for creating them.

I also rely on Achille Mbembe’s characterization of the “aesthetics of vulgarity” in postcolonial contexts to understand this phenomenon of sexualized and lewd frenzy in the RHU, specifically in medicalized contexts that involve physical closeness and crossing social boundaries with the body. Mbembe conveys how the colonized mobilize “fluid identities” and using the signs and symbols of state power to transgress party slogans and political messages, investing them with the grotesque and obscene. Rather than the obscene being assumed to be some intrinsic quality of postcolonial subjects (or of RHU inmates classified as the “worst of the worst”), he understands this improvisational style as a way to critique the intimacies of state power and engage in the politics of the postcolonial governance:

[I]t is not enough to bring into play the mouth, the penis, or the belly, or merely to refer to them in order to automatically produce obscenity. The mouth, the penis, and the belly – as structuring principles as well as objects of verbal acts and popular laughter – are in fact given multiple and ambivalent meanings. They are called upon to comment on various aspects of social life – a relationship to time, to play, and pleasure. In short, they are mobilized by those who want to make a statement about human existence and the ordering of society, death, inequality [...]” (Mbembe 1992:9).

Rather than acts of resistance that directly combat state power, Mbembe describes these processes as “the mutual ‘zombification’ of both the dominant and those whom they apparently dominate” (1992). Hence, these kinds of performances mire all actors in the muck of state-sponsored violence and institutional disparagement. While it is possible to confine people and impose material discipline and control, it is impossible to do so with signs and language.⁹ The inmate who asked if I would take his temperature rectally,

for example, offered an analogy between the violence of sexual assault and the violence of taking one's temperature – one that could also be extended to breaking the fleshy barrier of the skin during an injection. It is in this way that an intervention as outwardly mundane as a vaccine can elicit such varied and charged responses. “Confronted with the state's eagerness to cover up its vulgar origins,” says Mbembe, “people are simply bearing witness, often unconsciously, to the fact that the grotesque is no more foreign to officialdom than the common (wo)man is impervious to the charms of majesty,” drawing the parallel between the state's closeness to obscenity and the subject's desire for authority (1992:14). RHU inmates were engaging in commentary about the social life of incarceration and vulgarities of wardship through the medical metaphors of toxic exposure, emasculation, and care under security that then created reciprocal discomfort and *insecurity*.

It was vital when seeking care for inmates to “size up” individual healthcare providers in order to anticipate how a request would be handled as well as how and to what degree they would have to validate their medical claims. The comments we received during the flu clinic were in a sense also part of that process, allowing inmates to analyze how providers and other staff reacted to certain comments and what forms of complaints or derogatory comments caught their attention. Inmates stood to gain little appreciable practical benefit from making this kind of commentary. A goal of convincing staff to provide better or more comprehensive healthcare was unlikely to succeed; pointing out the unsanitary and logistically difficult injection practices was not likely to change them. The inmates' own responses to the one inmate's rape allegations reinforce this idea: they dismissed his question by reiterating that the flu clinic would not take on such an issue.

Instead of achieving some specific practical change in providers' behavior or affecting the implementation of the prison's security policies, inmates were able to gather information about how those policies might be differentially enacted by individual staff members. For example, an inmate could assume that a joke at his own expense might align Ron with him. Though Ron might be less likely to respond or take an inmate seriously when venting concerns about infection or experimentation, a joke might engage him. Sometimes these profiles even translated to nicknames, like “Black Diamond” for

the cold, hard demeanor of a short African RHU nurse who admitted she had no tolerance for “inmate games.” The nickname was born in the RHU, but eventually found its way to the medical unit. Inmates passing through the dispensary would say, “Don’t try anything with Black Diamond. ... She cuts deep!” Whereas other expressions of inmates’ frustrations with poor or absent medical care may have taken the form of submitting grievances, filing formal legal complaints and lawsuits, or making specific arguments in their claims to medical providers, this form of practical engagement with healthcare providers occupied a different role by eliciting working information for navigating the implementation of prison policy in healthcare delivery.

Officer Cook, who started some of her training in the RHU, had once mentioned that inmates in the RHU were good at picking up on individual insecurities so that they could use them to their advantage. She described how this practice made her feel and voiced what she imagined as inmates’ internal monologues as I pushed her to consider how the inmates in the RHU are the same ones who are seen to act appropriately in the general population:

CO Cook: It’s tough to deal with those guys because they’re in for 23 hours and when they’re behind those doors they say all types of prerogative, provocative... derogative, is what I’m trying to say... all types of stuff to you. And you have to try to suck it up, and some of it hurts! Some of it hurts. But you can’t show them that it does.

Nick: What do you think drives that kind of behavior there? It seems like, for the most part, the men are there temporarily and don’t act the same way when they’re in the general population.

CO Cook: Those are the ones that go down there and turn! Those are the ones. You see ‘em out here, [*Switching to the voice of a hypothetical inmate*] Hey, how you doing? Have a good day today. [*Switching back to her voice*] They get down there and call you all types of names. All types... I don’t know what drives it!

Nick: Do you think one is their “true” self and one is not?

CO Cook: Absolutely. They’re trying to pass the day. If they’re passing the day and they can get your day upset, why not? Why not? [*Voicing the inmate*] If I could aggravate her all day, why not? To hide my own aggravation. [*Her voice*] I don’t know. I’m not a psych, I’m just guessing. [*Inmate voice*] I’m disgusted and

upset with my situation, so I'm gonna make her day bad, too, because mine's already bad. [*Her voice*] Maybe that's why they do it, I don't know... I don't know.

Thinking more globally about the effects of these kinds of exchanges in the RHU, it becomes important to understand how the staff understood and handled these mocking gestures. Officer Cook suggests that she would “suck it up” and that these remarks came both from a place of spreading the negative feelings inmates had and as a way to simply “pass the day.” The taunts we received during the flu clinic were plentiful. In addition to the comments already discussed, inmate taunted James for being Asian, told me I looked like “the Italian guy” from the television show *The Mindy Project*, and called Ron “Kenny Rogers,” making fun of his full cheeks, scruffy face, and white hair. These vocalizations were treated indiscriminately from those that addressed medical issues and concerns. No one really answered or corrected the inmates when they asked if they were getting experimented on; nor did anyone advise the inmate about how to go about reporting and receiving appropriate healthcare after an alleged rape. Thus, while inmates' remarks may have provided them with some information to navigate security and healthcare delivery, they also encouraged providers to dismiss inmates altogether. The advice that I was given when walking the gauntlet “not to engage” with any of what the inmates had to say because it would “encourage them” therefore often extended to interactions for which medical services should have been engaged, thus limiting inmates' access to care.

After finishing on J Block, we moved across the road to L Block, a newer block, which was mostly administrative and disciplinary segregation, where stays were somewhat more temporary – typically measured on average in months rather than years. This newer facility was also arranged as a panopticon, but in a more contemporary, two-tiered style with blocks arranged in an “X” and cells with sliding metal doors instead of bars, similar to most modern depictions of supermax facilities. James said that he did not want to give the vaccines anymore because his arm was getting tired, but I sensed he was also growing weary of being at the forefront of receiving inmates' comments and, maybe more importantly, was uncomfortable giving the vaccines through the small space of the

wickets. Ron said he had to stay at the laptop, so I was recruited to give the injections. I briefly considered mentioning that I was not technically supposed to do that, but I did not want to make James continue if I could provide him some respite, nor did I want to get into a technical discussion of how my confusing role there prohibited me from assisting, so I agreed.

We made our way with an officer escort clockwise through the units on the block. This block had only four, named A through D, each one an arm of the overall “X” shape. The units had two tiers of cells on each side, facing each other in a large, open space. Here many of the cells were doubles, hence the reason, besides being slightly more euphemistic, to call it the “Restrictive Housing Unit” rather than solitary confinement. There were two stacked metal bunks bolted to the wall in these 10 by 8 foot cells. The computer started to malfunction after the second inmate, so Ron just started hand-writing the inmates’ numbers to keep record. I drew up the vaccines, balancing the vial and the syringe in different fingers of one hand, while using the other hand to reach through the slot to sterilize the injection site with an alcohol swab. Getting the right location over the deltoid muscle was not terribly difficult, although it was impossible to see all the anatomical landmarks at once. The harder part was angling the needle correctly (without crouching down and putting my head at the level of the wicket against the officer’s advice) and reaching through the wicket. I had to reach enough so that there was adequate extension to give the injection but not so much that my hands were completely inside the cell – something else I was told not to do because the inmate could grab them and take control of the syringe.

In addition to directing how and where the vaccines were given and how to interact with the inmates, the officer that was accompanying us on this block also offered commentary on the procedural aspects of the injection. Initially I changed my gloves in between patients, which took some time because they were small and made of vinyl, which caused them to stick easily to my skin and made them difficult to remove. The officer criticized me for changing them every time and said it would be faster to just leave them on: “You’re wiping the site with alcohol anyway!” Later he hovered over me as I drew up the vaccine and asked, “Are you sure that’s enough?” and when some

inmates' injection sites started to bleed, "Whoa there! Is it supposed to bleed like that? The other one didn't bleed." Part of his domineering behavior was typical of maintaining oversight of the entire unit, which extended officers' purview to the roles of healthcare providers even during regular sick call visits. However, officers on the unit were also frequently indifferent about what healthcare staff was doing, so in part my unfamiliar presence to him and status as a student enhanced his regulatory conduct. Speaking to what kind of toll working, let alone living, in this environment had, the officers who were assigned to the RHU were meant to undergo psychological evaluation every six months – a process many of the officers claimed rarely happened, compromising both their safety and the safety of the inmates they were meant to oversee.

On this block, too, the inmates made comments about medical experimentation. As with J Block, inmates were shouting out not to take the vaccine and alleging that we were injecting them with an experimental drug, telling those taking the shot to ask to look at the vial: "Yo, you gotta ask to look at that bottle. Look at the bottle and you'll see 'experiment number blah blah blah!'" They also made incisive and critical comments about the inappropriateness of their care. One inmate shouted, "They just students! They can't even get doctors and nurses in here! Not only they doing experiments, but they using us as guinea pigs for the students." Again, their comments were not groundless conspiracy. The other providers had regular clinic duties, and we were chosen because we were available by virtue of our status as students, and we were the appropriate gender. While the "guinea pig" comment was exaggerated in its suggestion that inmates were subjects of medical experimentation, the comment does accurately highlight that there was some experience gained that James and I stood to benefit from as trainees. Even the captain on the block recognized this as he walked over to me to comment: "Well, one thing is for sure. If you've never done this before, you'll be an expert at the end of the day!"

I admit I was struck with some paranoia myself faced with these comments critiquing care being that I was not technically allowed to administer the vaccine. Combined with the guard's over-involvement and my discomfort with the trickiness of giving the vaccine through the wicket, I began to sense a divergence from the reasons

why we were there (i.e. to provide a service) and the kinds of adversity, critique, and refusal that we were facing that I could not resolve in the moment. In essence I felt as though I was contributing to and actualizing some of the inmates' fears. Since this was one of the few moments I was able to inhabit the provider's subject-position, I felt the sense of uneasiness I imagine many of them felt in making the trade-off between feeling justified that what I was doing was ultimately true to my own sense of ethics, but might be unconsciously contributing to inmates' fears and discomfort around healthcare.

While we were drawing near the end of our rounds on L Block, we had two interactions that spoke to the conditions surrounding the acceptance of the vaccine that so many inmates had routinely engaged in tacitly. These encounters made some of the physical and political necessities of engaging with healthcare more explicit against this background of suspicion and fear that was present in all instances of healthcare acceptance, but which the vaccine had made more pronounced. The first interaction was with an older black inmate, nicknamed Badger, whom I recognized from dispensary visits where the staff always called him "needy," "a pain in the ass," and a "manipulator." In fact, a few weeks prior to the flu clinic he had shown up in the dispensary because of painful and bleeding hemorrhoids. While he was there he mentioned how he had lost bowel continence and had to wear diapers, and that none of the staff members in the RHU would clear away his soiled diapers because he had Hep C. An older white man, who was one of the prison's part-time physicians and not especially regarded for his bedside manner, was supervising the dispensary at that time. He called the practice "unacceptable," making notes in the chart to provide a method of diaper disposal, though it was unclear whether this had any effect on the unit. The staff cited concerns of contracting the virus if they were made to collect his soiled linens and have contact with other parts of the cell that "might also be contaminated," drawing out precisely how containing men had to involve more than just placing them in their cells to be forgotten about. Activities of regular, everyday care could not be neatly bound up in or deferred to healthcare services. They fell instead onto the correctional staff, who would often refuse to engage in that level of closeness with inmates or demonstrate the kinds of compassion required to assist in cleaning another person's bodily fluids.

When I got to Badger's cell door to give the injection, he asked my name. As I was responding and telling him my name, I glanced forward at the officer, out of Badger's line of sight, and saw him shaking his head, gesturing not to continue the conversation. If inmates were hostile or suspicious of a medical provider, they would often ask for the provider's name so that they could name them in a written grievance. I had seen some providers give inmates their names, where others refused, telling inmates it was "none of their business" and would even take off their ID badges or turn them around so inmates could not see. I sensed that the guard wanted to speed things up but was also advising me to distance myself from Badger's conversation with this in mind, given his reputation as needy and manipulative.

As I caught glimpses of him, I could see that Badger was very frail and his skin was thin, almost translucent. I was nervous that the shot would hurt him – or at least leave him sore for some time after. After I finished he stuck his face in the wicket, tilted his head up to look me in the eyes and said softly, "Thank y'all for coming down here to do this... you know, to the RHU and all." Badger had many reasons to distrust healthcare services. At a minimum this distrust was fomented by guards who refused to assist in his daily care, marking him as "contaminated," and the setting of isolation that accompanies placement in the RHU. Combined with the sources of skepticism collectively shared by his fellow inmates in the RHU and throughout the prison, his comment speaks to what an anomaly supportive care was in that environment, but also how important – despite inmates' ongoing critiques and refusals of care – the work of care was, and how there was still potential foster collaboration and communication about the fears, desires, and goals of care.

The second instance came when we arrived at one of the cells that was double-occupied. Both cellmates were white, and while one inmate took the flu shot, the other did not. The man who refused said, "I don't want none of that!" referring both to the fact that he was not confident what was in the vaccine and a general intention to "ride it out" if he got the flu. When his cellmate decided to receive the injection, he asked him why. "I got that flu last year and it was brutal man," he responded. "No way in hell I want to go through that again, especially not in here [the RHU]." Their quick exchange evidenced

the desire for protection in such a devastating place, and the logical gamble involved in trusting medical services not just to do their job, but to do it in a place designed to foster adversity and perpetuate confusion and suffering in isolation. The ambivalences articulated in these cellmates' reactions to the vaccine and demonstrated in Badger's healthcare encounters, just as they were articulated in the discourse during the general population clinic, expand the image of the prison as a site of pure, sovereign power. Through these intense contradictions and the kinds of actions they elicited, space is made for interactions between biopower and individuals with the potential at least to contradict if not overcome this hostile infrastructure.

Within the larger oppressive space of the prison – and indeed, the super-maximum security of the RHU – these moments of refusal and acceptance lay out the grids through which care and neglect, health and illness, and recognition and exclusion were able to pass. Moments that display the profoundly social nature of healthcare and how it is situated within local cultural worlds and individual vulnerabilities speak not only to the brutality of the environment and the types of institutional inertia that needed to be overcome (as in Dede's request to examine patients) in order to deliver/receive care but also to how healthcare always involves complex constellations of desire, fear, trust, and skepticism. Inmates' transgressive acts and refusals in response to medical intervention manifested the contradictions of wardship – the vulnerability of state ownership and the need for custodianship and care created by that ownership – mirroring the biopolitical coupling of care and custody. At the same time, acts of acceptance, which were relatively pervasive but felt scarce in the charged environment of the flu clinic in general and the RHU in particular, offered moments where biopower's contradictions might be embraced, and medicine's healing potential might be actualized through an acknowledgment of how medical intervention and medical authority can act with and against security.

Our final encounters in L Block reaffirmed the functional challenges in realizing that potential. For the first time in this unit I saw two men “fishing” for notes on an upper tier, where one man would throw a hand written note toward another cell, and the recipient would toss out a rope fashioned out of dental floss with a weight attached and

pull the note back to his cell. I was amazed at how well they did this, and surprised that they would even engage in the practice while they were being watched, especially now that the officer were in plain sight. The officer immediately and predictably walked up right behind me, yelling, “Cut that shit out!” They all instantly replied, “Fuck you, CO!” and he ignored them and went about his business. I was astonished; I could not believe they had pushed back so aggressively and how effective it was in dissuading the officer from pushing further. This attitude and reaction were then repeated in the clinical context when we ended our rounds. We were getting ready to move from Unit C to Unit D, and the officer walked in ahead of us and announced that we were there: “Medical’s here giving flu shots! Anybody want one?!” All of the inmates then responded in unison: “Fuck you CO!” He turned back to us, shrugged his shoulders and said, “I guess there’s your answer.”

¹ E. Richard Brown (1976), for example, describes how the Rockefeller Foundation’s tropical disease and hookworm programs produced profit by improving the energy of the labor force especially in the southern United States, asserted the United States’ power over disease through technical innovation, and assisted in the cultural and political domination of economically disadvantaged countries. Global smallpox and polio vaccination programs have also been deeply linked to colonialism, eliciting distrust and collective memories of experimentation and subjugation in their refusals (Arnold 1993; Feldman-Savelsberg et al. 2000; Ghinai et al. 2013; Yahya 2007) and attempting to offer “magic bullet” solutions to deep social, economic, and infrastructural problems (Anderson 2007; Closser et al. 2015).

² Subsidy funding sometimes came for grants written by private institutions, as became the case for HIV care during my fieldwork, and was sometimes allocated from the Bureau of Healthcare Services or the Department of Health.

³ Guillain-Barré Syndrome is an immune reaction that affects the peripheral nervous system, causing progressive ascending paralysis.

⁴ The pamphlets, distributed every year by the U.S. Centers for Disease Control and Prevention, are updated occasionally to reflect changes in the vaccine and different delivery methods (e.g. changes in recombinant proteins to protect against certain strains of the virus and live attenuated vaccines inhaled as mists) as well as public concerns – in this case especially a controversy over thimerosal-containing vaccines and an alleged link to Autism spectrum disorders and other neurological conditions. The attenuated virus vaccine, which can cause flu-like symptoms, was not administered at this clinic.

⁵ The move to reject the language of “offenders” and “felons” was inspired by a similar one pursued by the United States Department of Justice and was presented in the philosophy of Pennsylvania’s Secretary of Corrections John Wetzel to adopt a “people first” language, though importantly only to those who had been released from prison. Wetzel mentioned in a public statement:

Refraining from referring to those who have committed a crime as offenders, I do not excuse their behavior or minimize the impact they've had on those they've offended, nor do I disrespect victims, by respecting those who have victimized. Rather, I acknowledge the humanity of incarcerated individuals despite their damaging behavior, and, as importantly, acknowledge their capacity to change. [...] So if we're really going to embrace rehabilitation, then we can't send re-entrants back home wearing a label that dehumanizes them – such as “offender” or “felon” or “ex-con.”

This linguistic move, which was seen by many as the application of norms of political correctness applied to those undeserving of such consideration, was clearly negotiated within a field of politics that oscillated between victims and perpetrators, as if only one could be deserving of attention and advocacy. (Tom Jackman, “Pennsylvania Dept. of Corrections to discard terms ‘offender,’ ‘felon’ in describing ex-prisoners,” *The Washington Post*, May 25, 2016, <https://www.washingtonpost.com/news/true-crime/wp/2016/05/25/pennsylvania-dept-of-corrections-to-discard-terms-offender-felon-in-describing-ex-prisoners/>).

⁶ Many inmates who were sentenced to death and life without the possibility of parole were eligible for single cell status. Although Pennsylvania still sentences people to the death penalty, there has been a de facto moratorium on executions since 1999, which became an executive order under Governor Tom Wolf in 2015. He cited the cost of executions and their ineffectiveness as correctional policy as the reasons behind granting inmates temporary reprieves rather than humanitarian or constitutional concerns. In a statement that echoes my arguments about the primacy of punishment and lack of inmate deservingness, Governor Wolf stated, “My decision to issue temporary reprieves came after significant consideration and reflection, and was in no way an expression of sympathy for the guilty on death row. [...] My only sympathy lies with the family members of the victims of these horrible crimes” (Santoni, Matthew. “Pa. Supreme Court Upholds Gov. Wolf’s Death Penalty Moratorium,” *Pittsburgh Tribune Review*, December 21, 2015, [http://triblive.com/news/adminpage/9672521-74/wolf-pennsylvania-court.](http://triblive.com/news/adminpage/9672521-74/wolf-pennsylvania-court/)).

⁷ “Jawn” is Philadelphia slang that functions as an all-purpose noun that can be used to stand in for or refer to objects, people, abstract concepts, and, in this case, places.

⁸ Although during my fieldwork, I only ever heard of it happening to a healthcare provider once – to Mara, the military nurse briefly introduced in Chapter 3. From what I had heard, she was struck with the inmate’s concoction of urine and feces when the officer to whom it was supposedly directed was out of the range of his throw, and she became a secondary target.

⁹ See also Roseberry (1994) for a discussion on how hegemony is a contested political process that involves making and re-making meaning in language.

Chapter 5 – Waiting for Justice

One of the things that keep me going, not that I don't believe in poetic justice – at one time I was saying this to myself to keep myself sane. But I don't want poetic justice. I want the real thing! To hell with poetic justice!

- Eddie

Justice Delayed...

The paradox of situating a right to healthcare within a legal system that has systematically denied the rights of those to whom they were supposedly entitled presents a problem for the notion of justice. How can the law be seen as oppressive when operating within the United States' criminal justice system – a state mechanism for the production, regulation, and suppression of difference – and potentially liberating when framed in the discourse of democratic rights or fairness and equality? This question took on particular salience for inmates seeking forms of justice in the law related either to their convictions or their healthcare, causing the two processes to become thoroughly entangled with one another. In a way the relationship between the law and justice paralleled the relationship between medicine and health in prison; seeking out either health or justice exposed inmates' vulnerabilities, fears, and anxieties of being held in the state's custody. How, then, could inmate-patient-appellants rationalize turning back to the legal system that incarcerated them for justice – a system that has been built throughout a century of increasingly harsh and discriminatory policies and sentences under the pretense of proceduralism and impartiality¹ to be so profoundly *unjust*? In this chapter I attempt to grapple with this contradiction by outlining how inmates' desires for justice became articulated in the law and worked inside, outside, and alongside it. Understanding justice in this way not only requires reconfiguring the paradox outside the restrictive dichotomy of oppression and liberation, but it also requires rethinking the relationship between justice and time.

I am forced to reckon with Martin Luther King's words in his "Letter from Birmingham Jail," where he wrote, "For years now I have heard the word 'wait.' It rings in the ear of every Negro with a piercing familiarity. This 'wait' has almost always meant 'never.' We must come to see with the distinguished jurist of yesterday that 'justice too long delayed is justice denied.'" (King Jr 1963). Many inmates experienced the delay of the kind of justice that King spoke of, and for them this delay did constitute a denial. However, to read the telos of justice as a denial would mean that inmates would no longer seek it. Justice requires us to wait, and to continue waiting, though we can also see the process of waiting as productive of its own forms of justice and as conducive to restructuring the relationship inmates had to justice as an end goal.

In Franz Kafka's parable, "Before the Law," he writes of a nameless "man from the country" waiting for a doorkeeper to grant him access to "the Law." The doorkeeper allows him to wait, but warns of other barriers that lay beyond. "These are difficulties the man from the country has not expected," writes Kafka. "[T]he Law, he thinks, should surely be accessible at all times and to everyone, but as he now takes a closer look at the doorkeeper in his fur coat, with his big sharp nose and long, thin, black Tartar beard, he decides that it is better to wait until he gets permission to enter." After years of waiting, when the man is near death, he asks the doorkeeper a question:

"Everyone strives to reach the Law," says the man, "so how does it happen that for all these many years no one but myself has ever begged for admittance?" The doorkeeper recognizes that the man has reached his end, and, to let his failing senses catch the words, roars in his ear: "No one else could ever be admitted here, since this gate was made only for you. I am now going to shut it" (Kafka 1971).

Kafka's man from the country represents all of us who wait before the law for it to dispense justice that seems as though it will never come. The weight of this parable in light of a racialized criminal justice system is made even starker when read along with King's fierce declaration. Waiting in this manner reproduces the condition of subordination to the state and to the law, where obedient legal subjects are made susceptible to the state's sovereignty.² The ability to instantiate the law seemingly arbitrarily gives legal subjects the hope of justice. Kafka suggests that even if we know,

as King suggests, that we may never get through the door to gain access to the law, or if there is nothing that remains behind the door, the relationship of waiting before the law for justice might not change. As obedient subjects, those who rely on the law's promise of justice, we are drawn – even compelled – to wait for it. In the labor of waiting, however, we are forced by the denial of justice to see justice as operating in the here-and-now. With this in mind I explore the ways inmates, who are frequently made to wait – wait to see the doctor, wait for treatment, wait for freedom, wait for justice – make justice in the meantime.

Inmates were often haunted by injustices – the injustices that led to their incarceration, the injustices of being made into the biological and financial property of the state, the injustices of having a lack of control over their health or healthcare, and the injustice when healthcare failed to be upheld as a right and instead reinforced punishment, prioritized profit over health, or responded to suffering with indifference. The promise of justice motivated endurance through all of those injustices and held the possibility to hold people and institutions accountable for their wrongs and responsible for their obligations. Furthermore, justice could allow those who had been marginalized and disenfranchised by the state the opportunity for state recognition, a form of citizenship that was consistently forestalled by their hybrid citizen-subject status as wards. When understood as such – as the recognition of the humanity and human suffering of inmates as legitimate and worthy of equal social status as the citizenry – the concept of justice represents the very stakes of care in the context of confinement.

In what follows I outline three inmates' experiences of making justice in the context of waiting for the fantasy of amends or restitution, made even more impossible given that they have already served time and suffered as a result. In this sense no amount of future accountability or repayment can undo harm caused, but in reconfiguring their relationship to justice, these men are able to endure and make meaning. Because they are not seen as full citizens, but quasi-citizens, the inmates I discuss make claims both to the state by appealing to the logics that underlie the structuring of a Constitutional right to inmate healthcare and to notions of universal humanity. Their experiences outline attempts to reclaim sovereignty from the state and apply forms of embodied sovereignty

while also speaking to the law in its own terms. In combining these two logics and forms of action, they impart their desires for recognition into the paradox of rights in the law. They hope that actors within the legal system will perform the work of objectivity while also investing their decisions with affective forms of recognition. In this way, these inmates invest their petitions to the law with their vulnerabilities and seek to produce affective responses to suffering and humanity within the actors who uphold the law (Cody 2009; Hull 2012).

Effectively navigating the ideological and institutional infrastructure of inmates' rights inmates demonstrate their abilities as creative "bricoleurs" who "create structures by means of events" (Lévi-Strauss 1962:22). Understanding the ways in which inmates made and sought after justice adds richness to the idea of justice as a horizon of possibility, and how current struggles break down and reframe that horizon and help shape the conditions for justice in the interim.

First, I introduce Peter, a 56-year-old white inmate that I met during his hunger strike. When he was 15 years old, Peter was sentenced to life without parole. During his incarceration he had acquired legal knowledge in the law library and intimate familiarity not only with the legal precedents related to his case, but with all the institutional policies and procedures in the Department of Corrections. While waiting for the Supreme Court ruling banning juvenile life without parole sentences to be retroactively applied in Pennsylvania so that he might be made eligible for parole, he staged a hunger strike when an officer accused him of instigating a riot. His creative use of the hunger strike to protest the loss of his single cell and his property not only wagered his own body and life, but also effectively leveraged his knowledge of the legal system to exposing the arbitrary sovereignty of the institution. His effective use of the objective, capitalist value of property over the more subjective determination of deservingness implied in justice related not just to his own property, but to the logics that made him the property of the state.

Second, I expand on Roger's attempts at justice for the delay in diagnosis and treatment of his lymphoma. His cancer encouraged a certain perspective on the remainder of his time in prison serving two life sentences on felony murder during a robbery. Roger

discussed not only the desire to spend time with his family and involve them in his end of life decisions, but the fact that since his incarceration, he has built a reputation as a “legal eagle” and wants to divert his attention away from pursuing his compassionate release – which he acknowledges as guaranteed death since he will not be able to afford his expensive chemotherapy – and toward spending his time being treated, receiving visits, and helping some fellow inmates pursue their own legal cases. Roger’s case highlights the cruelty of having to remain in prison as one of the few ways one can actually make claims to the state, and the reliance on financial logics that place monetary value on inmates’ lives.

Lastly, I return to Eddie in order to discuss his legal struggles to combat a wrongful conviction. With the help of his friends and family members, he raised money for legal fees through community events and crowdsourcing in order to pursue a formal appeal to his case. Through these appeals and his everyday actions within the prison, he relied on the common sense of suffering and an assumption of rational action within the law while acknowledging what he considers to be a fundamental flaw in the justice system – that it is based on a system of debt. Eddie realized the hypocrisy of seeking justice in a system where his punishment was meant to repay a debt to society that was impossible to repay. In the same way he was expecting that system to repay its debt to him. I look at how Eddie’s attempts to resolve this hypocrisy have intersected (in both tragic and hopeful ways) with the medical issues that he has faced during his incarceration to effect a kind of justice that may not be ideal, but could be satisfactory. I also show how Eddie has dealt with his 42-year incarceration while maintaining his innocence through individual tactics and more collective advocacy efforts.

Peter

Ten days into a hunger strike that he started in the RHU protesting punitive measures taken against him in connection to the A Block protests in the dining hall described briefly in Chapter 1, Peter Ackerman, a 56 year-old white man, was brought to the infirmary and placed in an MOC. In theory this allowed his health to be monitored more closely, and it afforded the opportunity to avoid having RHU officers open up his cell every day so that nurses could weigh him and record his vital signs. (However, see

my description of the MOC in Chapter 3). After a few weeks in the MOC where the healthcare staff continued to conduct their clinical rounds daily, generically checking in recording his vitals, I could see how he was losing weight in his face and stomach. The sides of his face framed by his short, white goatee seemed sunken, and the same jumpsuit that was once tight around his hips when he was admitted to the infirmary now draped at his sides and bunched in the front. As I later got to know him, I learned that Peter had a very serious personality. While he was kind and affable, he never went out of his way to be pleasantly friendly also was quick to lose patience if he felt misunderstood – something that I saw commonly among inmates in clinical settings, but did not often experience in one-on-one interviews.

One morning after arriving at the prison, I went into the security bubble of the infirmary and was greeted with some chatter about overnight events. Officer Norris, a forty-something white female CO who was shorter than average and always wore her thin, brown hair pulled back in a ponytail, was excitedly discussing with the nurse Silvia how Peter had broken his strike overnight. Officer Norris was saying that the night shift officer had talked Mr. Ackerman into eating some applesauce. “We got him!” she exclaimed. “Ackerman caved and ate some applesauce last night! Ship him outta here. We don’t have to babysit no more!” Dr. Keller then chimed in with some information that he had reviewed the day prior when discussing all of the ongoing hunger strike cases with some of the regional directors for Correct Care Solutions, the then healthcare vendor, and DOC officials. He mentioned to Officer Norris and the rest of the room how Peter’s lab results may be evidence that he was losing weight but was not malnourished, and that this data might also prove that he had been “sneaking food” all along:

Dr. Keller: You know he’s been eating anyway, and I brought up those labs to the regional directors and I said, “What do you guys think? Prealbumin³ going up, normal CMP [complete metabolic panel], thirty-some pounds of weight loss.”

CO Norris: He’s on Jenny Craig... right here at Graterford!

Dr. Keller: They said, “It sounds like he’s eating to me!”

CO Norris: It’s documented on the 17X [CO shift report].

Dr. Keller: It's documented on the 17X that he was given *and ate* applesauce?!
[laughs] Because I brought that up to them yesterday, I said there's no documentation, but the same shift, they [inmate workers and/or COs] are slipping just a little bit for him to eat, you know... but [they say] "We support your cause, so keep losing weight."

CO Norris: Well with Mr. Young. Did you see me push the sandwich underneath Young's door? It's very easy to do.

Dr. Keller: Yeah.

CO Norris: So, but anyway...

Dr. Keller: So he did eat?

CO Norris: Apparently so. We'll ask him this morning.

Dr. Keller: [gesturing to the CCTV monitors mounted in the corner] Is it on the video?

CO Norris: [gives Dr. Keller a suspicious look] These things don't have video. There's no tape.

Dr. Keller: Oh there's no tape?

CO Norris: [shakes her head] Why should there be?!

Dr. Keller: [looks at me] I ask a lot of stupid questions, don't I? I have to think before I speak.

It was surprising to hear that the videos monitored what was going on in the cells but did not record anything, although this ultimately reinforced the paradigm Michel Foucault describes for surveillance and the reproduction of normative behavior in which the presence of the cameras themselves and the idea that someone *could* be watching guides inmate behavior more than actually being watched (1975). After discussing a few more patients in the bubble, we then made our way down the hallway, seeing patients along the way, until we reached the MOC at the end where Peter was. The officers opened the first locked door to the smaller vestibule, but Peter's cell door remained closed and locked. Dr. Keller addressed the labs and the applesauce with Peter through

the slot in the door while Peter lay on the bed staring directly across at the cinder block wall:

Dr. Keller: A couple of things I wanted to go over with you. I saw in the record from last night that you had some applesauce [*Peter sits up with a groan, looks at Dr. Keller and starts shaking his head*] and I'm fine with that. That doesn't mean you take somebody's hunger strike away for having a little bit of applesauce. The blood work that I got back obviously shows that you've been eating some food.

Peter: [*shakes his head again*] No way.

Dr. Keller: Well all I can tell you is when I look at the lab work, for someone who, according to what I record every day in the notes – and I'm not talking about water, because I know you're hydrated – but according to your blood work, your proteins, and the markers that we use called the prealbumin that I spoke to you before, are getting better. And for someone who would have missed approximately thirty days of food, you should almost be to the point where you look like an Auschwitz person. Your protein should be severely depleted, because even though you're drinking water, you're hydrated, and your kidney function is fine... the only other thing that I would really want to check on to see what kind of condition your body is in, is to check your urine – get a urine sample from you. But your electrolytes, your proteins, your liver functions, are all **normal**. And that's the second time that I've checked them, and that's why I do this test called the prealbumin.

Peter: Well I'll tell ya... You've got a camera right here. You can see I'm not eatin' anything.

Dr. Keller: Well I don't... I don't see anything during the daytime. That I don't see. I don't know what goes on at night. It was, you know... and this particular case it was one of the guards that wrote down what you had, and they've never written down anything that you've eaten in the past. So... I'm not saying that I'm still not concerned. I'm don't want you to think that just cuz someone eats a little something, there's not a hunger strike, there's not a concern for your wellbeing. That's the reason that I do the blood work, because blood work doesn't lie. And in this case, the prealbumin that was below the normal range, went up. **It's still abnormal, but it went up** instead of continuing to decline, which is what I thought it would have been. And as a matter of fact, I was over at the DOC yesterday and I was discussing this with some of the other physicians that were there, and they sort of all came to the same conclusion that you must be eating something. Not to the point of you losing weight, you're still losing weight, that's obvious. You've lost about thirty-some pounds over the last month, but it seems like you have to be eating something, just not enough to keep you from losing

weight.

Peter: I've also been vomiting.

Dr. Keller: I know, but think about it... somebody who goes thirty days and only drinks water, your body should be in starvation mode, and you should be... all of these things start getting so out of whack that I need to be concerned about your wellbeing, and I talked about that. Based on how you look, how you present, what your blood work looks like, thank god, it's not to the point where I need worry about getting court orders and feeding you or anything like that. I am concerned about the vomiting. That's an issue, although the blood work that we did certainly didn't show that you're dehydrated, or that your chemistries were off because of the vomit, so that's a good thing. So we're going to continue to monitor you. I'm not going to change the way I'm doing anything for you. I'm going to want to get a urine sample from you just so I can dip it and look for sugars and proteins and things. It might also give me a clue if there's an abnormality in your system. Ok? And that's easy to do. We have a dipstick, and we can do it and that's done. [pause]. So i'm going to keep doing what I'm doing [...] I'll continue to monitor you. If things start to decline, it's not that I don't want to believe what you're telling me. I have, ever since I've met you, I have no reason to think otherwise. I'm going by the blood work, and what it shows just doesn't jive for someone who hasn't eaten any solid food.

Peter: I understand what you're saying, but what I'm saying is I got no way of getting food. I'm in a locked cell. There's no way someone's bringing food in here, under a monitor, so...

Dr. Keller: Right. And unfortunately I don't know what's recorded, what's not recorded. I don't know any of that stuff.

Dr. Keller then moved on to discuss Peter's vomiting. Peter was concerned about a possible infection, given that the inmate who occupied the MOC prior to his arrival had been smearing his feces on the wall.

Dr. Keller: As far as the vomiting goes, you're still drinking water...

Peter: Not a lot! A small cup. I notice how much I drink, because it all comes up.

Dr. Keller: So you're not keeping any of the water down at all?

Peter: Some of it, yeah, cuz I only take like a half-cup at a time.

Dr. Keller: Ok well that would be another good reason to check the urine. [...]

Peter: Is it possible that the vomiting is caused by stomach infection?

Dr. Keller: No, your stomach has acid in it. There's normally not a risk of infection. Now, if you ate something bad, and you had a viral stomach... like a gastroenteritis, that would be different.

Peter: I was just thinking about the guy who was in here before shitting all over, picking up some *E. coli* or something.

Dr. Keller: Well that shouldn't be. Normally with an *E. coli* infection, it's not an acute thing like a food poisoning. And that usually leads to watery diarrhea, not nausea and vomiting. But hey, that's something that we'll have to watch, because if your blood work shows that you're losing potassium in your vomiting, if you start to get dehydrated because you're not handling the water like you're used to, then that's something that we'll have to address, whether that's IV fluids or something to pump you back up. You know, is it the fact that your stomach is getting so shriveled from lack of eating, that it's rejecting what you put down? That usually does happen...

In accordance with my discussion of the importance of a reductionistic medical gaze in prison healthcare in Chapter 3, Dr. Keller was relying on the supposed objectivity of the lab results not only to guide Peter's treatment (or lack thereof), but also to make moral and normative judgments about his behavior and how he "should" look. That is, he was expected to look like a concentration camp survivor, rather than as a man who went from being overweight to having lost thirty pounds – or, per Officer Norris's earlier remarks, he appeared to them only as if he had gone on a diet. Dr. Keller even gave Peter conflicting information about his lab values, stating at first that they were normal and then that his prealbumin was abnormal, but paradoxically rising (bolded above for emphasis). Despite the fact that prealbumin is often abnormal only in cases of extreme starvation and is a poor marker of nutritional status in general⁴ and that Dr. Keller suggested that eating in order to sustain life would not disqualify an inmate from pursuing a hunger strike (or at least that eating made him happier that he would not have to file for a court order for forced feeding), the accusation that he had eaten further limited their involvement in his case to treating Peter's lab results rather than Peter himself. When faced with the possibility of the more objective proof of his food

consumption on the video monitor, Dr. Keller simply denied knowledge of what was taped and deferred responsibility of reviewing, interpreting, and utilizing that information.

Tragically, when Peter – and most inmates – relied on the record of that surveillance as evidence to support their own claims, it was conspicuously absent. Surveillance could only be relied upon to produce obedience in theory, but not as a means of proving that obedience (let alone obedience to a poorly-defined standard) actually occurred. Therefore, the only item that could be utilized to gauge truth claims was the blood work, which was in the interpretive hands of the healthcare staff and served to limit their concern for Peter’s nutritional status and even made his vomiting suspicious. In addition to the indifference to Peter’s vomiting that led Dr. Keller to delay concern until he saw an abnormal lab value, when we stepped out into the hallway, Dr. Keller asked the nurses and officers, “Did anybody see him vomit on the screens? Like, at all?”

After eleven more days (forty-one in total), Peter’s hunger strike was resolved, and I was able to debrief the experience and outcome with him once he had recovered and was placed back in the general population. His experience with the hunger strike was common to that of many inmates that I met, and his strike took place within the larger context both of the A Block protest against prison food rations/prison conditions as well as a court decision I will come to later that had the potential to affect his sentence, the sentences of around 500 inmates in Pennsylvania, and up to 2,000 inmates nationwide. Thus, Peter’s hunger strike is important for understanding the context of individual and collective justice-making. As one of the few white men who participated in my research, his representation here is relatively proportional to the 24 percent of white men who were incarcerated at Graterford. His background and the nature of his case also continue to speak to some of the workings of race and class in the criminal justice system.

Peter came from a predominantly poor, white borough in a county closer to central Pennsylvania, where he grew up in a small house with members of his extended family. When I met him he had served almost 40 years in prison on a life sentence without the possibility of parole. When he was 15 years old, he was tried and convicted as an adult of the murder of one of his relatives that had happened almost a year prior.

After holding Peter in custody in order to delay the trial long enough to make a better case for him to be tried as an adult, the trial presented gruesome descriptions of the murder and psychological profiling of Peter's apparent lack of remorse and premeditation, and he was found guilty. The judge subsequently carried out the automatic life sentence mandated for first- and second-degree murder in Pennsylvania. In addition to the delay of his trial, Peter was assigned one of Pennsylvania's few public defenders outside of Philadelphia because of his inability to afford a lawyer. All of these conditions contribute to what Peter considers to not only be an unfair trial that took advantage of his youth and indigence, but also of Pennsylvania's harsh sentencing policies, especially toward juveniles.⁵

In 2012 the Supreme Court decided in *Miller v. Alabama* that juvenile life sentences violated the Eighth Amendment prohibition against cruel and unusual punishment, citing that juveniles had not yet fully developed a sense of morality and that they held the capacity to change as individuals over the rest of their lifespan.⁶ This ruling made it unconstitutional to continue issuing mandatory life sentences to juveniles moving forward, and allowed judges more discretion in individual cases to apply a range of sentences. This action was met with mixed reactions both on the Court and in the public because, on the one hand, any sense of justice within the judicial system relies upon assessing individual cases and assigning a fair punishment accordingly, and on the other hand, the movement to impose mandatory minimum sentences was in small part argued as a way to remove the kinds of bias that might be introduced to the judicial system through taking individual characteristics and circumstances into account in sentencing. Obstinate about changing its sentencing policy, Pennsylvania, under Governor Tom Corbett, eventually did pass a bill that did not make life sentences for juveniles mandatory, but still offered them alongside decades-long mandatory minimum sentences.⁷

It was still unclear what effect, if any, the Supreme Court ruling in *Miller* would have on the thousands of inmates like Peter who were already serving the life sentences issued to them as juveniles. There was yet no clear indication that it would be applied retroactively. Pennsylvania had around 500 inmates – the largest number of any state –

...serving life without parole sentences they received as juveniles.⁸ Peter, a self-described “legal eagle,” who stunned me not only with his knowledge of the law, but his uncanny ability to recite from memory legal statutes in the Pennsylvania code and prison policies in the inmate handbook, was reviewing case law and attempting to appeal for parole on the grounds of this new decision. In the midst of this appeal, the Pennsylvania supreme court decided that it would not retroactively apply the findings in *Miller*, and juveniles sentenced to life without parole in the commonwealth prior to 2012 would remain incarcerated for the rest of their lives.⁹ This did not deter Peter, who was still working to have his case heard again.

It was while pursuing this appeal and waiting for it to be heard that Peter was issued a misconduct for “unauthorized group activity” when he allegedly stalled the food service line in the dining hall as part of the actions that lead to a block-wide meal refusal and disobeying the order to return to their cells. After receiving the misconduct, he was placed in the RHU, and his property, housing assignment, and single cell status were revoked. He recounts being issued the misconduct and his reliance on objective data and video surveillance to support his claims there, as well:

Peter: It’s a misconduct that nobody in here is going to be able to beat.

Nick: Why’s that?

Peter: It’s your word against the guard’s word. They’re never going to take either word over a guard’s word. They have to back their guy. It’s an unwritten rule... they have to back their man up. There’s no concrete evidence. The security camera... yes, they’ve admitted... the administration admits that the security cameras did show them what my testimony to the security office said, but there’s no audio, so there’s no proof that I didn’t say this, or that I did say this. They just have his word against mine, and my experience in the last 40 years in the DOC is very simple: I could have brought every single inmate in that chow hall down there to testify that I didn’t say what he said I said, and they’re still gonna take that guard’s word. That’s the DOC.

In such a system that was designed to work against him, I wondered why Peter would pursue a hunger strike – a very local, regulated, and ritualistic effort that was self-contained within that system. When I asked Peter why he decided on the hunger strike

over some other kind of administrative appeal to the misconduct, he stated, “Just a gut instinct I guess you could say. Something just told me that... you know, that this is basically the only fight I got. There’s no paperwork I can put in, nothin’ that’s gonna change anything, but I knew that a hunger strike would bring some kind of attention to the situation, and I gotta fight my fight.”

Peter further explained to me that it was never really about overturning the misconduct or proving that he had not done what the prison staff was accusing him of doing. Rather, the strike was about restoring the quality of life he had worked to build in the prison – getting back his single cell status and the property that had been taken from him. He had associated the restoration of his quality of life with the notion of justice, whereas the truth of the misconduct (i.e. his innocence) represented a sense of fairness that for him was distinct and perhaps even unattainable. “I had already resigned myself to being stuck with the misconduct,” he said. “I just wanted that quality of life restored. [...] I put in my request to the superintendent... that I’m not even gonna suggest that you be fair about this, because life isn’t fair. I’m just askin’ for justice.” Not only was proving his innocence an inaccessible and unreliable fantasy in this context, but it was one that Peter had been conditioned to not expect. Life for Peter was not fair, but justice in this case seemed to be tied a more obtainable standard – the quality of life that he had built and felt entitled to as someone who was serving a life sentence.¹⁰

The fact that Peter was serving a life sentence and faced the distinct possibility that his case would not be reheard as a result of *Miller*, it is easy to see why he placed such a high premium on his quality of life within the institution. In his case waiting in a period of indecision and uncertainty for his life sentence both affected how he negotiated the demands of the legal system in terms of what kinds of evidence it responded to as well as how he prioritized what he wanted and expected from it. He both valued his quality of life and saw it as the most feasible claim he could make because it was tied to the state’s obligations to him as a ward – a legal designation that he be assigned a single cell and the expectation that he be allowed some of his property. He also came to realize that he could not rely on forms of objective evidence in the way he might have hoped.

As he expected, Peter did not get the misconduct overturned in the negotiation that ended his hunger strike – a negotiation that was ultimately facilitated both by his navigation of the legal system and a support network that lobbied his case to DOC officials in Harrisburg. He was, however, granted his single cell status, some of his property was returned, and his job pay was only partially scaled back temporarily. When I spoke with him after his initial return back to the general population, however, they had placed him on a different block, which he claimed was not part of the original agreement and an essential part of the quality of life he wanted restored, indicating how essential the support system on his old block was for him:

Plus there's like 7 people over on A Block. They're the only people in this jail I have a real relationship with, and have had a real relationship with for the past 25 years. Those are people that – as a group – we see somebody getting ready to go off the deep end... something's happened that's got them real angry and they might be thinkin' about doin' something stupid... the rest of us will get with that guy, talk him down: "Hey, you need to take a step back, take a deep breath, look at this objectively. There's gotta be another way to do something. Don't do something stupid. You know, you've gone this long without trouble." I've been involved with doing it with one or more of them and all of them have done it with me. And I felt, you know... if I wind up going to another block, I'm gonna lose that support system, and I'm gonna be in a lot of trouble.

While Peter highly valued these parts of his quality of life because his life sentence made them such a high priority and a minimum expectation from the state, the appeal to that sentence also paradoxically created the conditions for which his life was systematically de-valued, even by Peter himself. Peter described his willingness to take part in the hunger strike as “the only fight he had” and frequently mentioned how he was willing to put his life on the line because the state had control over it. Yet, this was put in tension with the ongoing appeal and the potential for it to be approved and for him to be released on parole, undermining the life sentence precondition that allowed him to see his life as the only thing he could wager. This created some hesitation with his support network outside of prison, namely his female cousin who was concerned that he would draw too much negative attention or jeopardize his appeal with the hunger strike and accrue more disciplinary action:

She [Peter's cousin] said, "You got this case, and you got a really good shot at coming home, but if you kill yourself on hunger strike, that ain't gonna happen!" and I'm like, "Oh no, I'll make it home. It might be in a body bag, but I'll make it home!" It's ... I know it sounds strange to be so cavalier about it, but it's gotten to the point where my life... and I tried to explain to the deputy when I wrote to her... a life without quality of life, there's no reason to have one, and you basically stole the quality of life it took me this long to get, and it's not a big thing. It's not some big fancy house or all this stuff. My cell didn't have that much luxury in it, so I didn't feel like I was askin' that much of 'em. You know... my opinion and theirs is totally different, I'm quite sure of that. You know, you have staff here that believe that we shouldn't have anything here that the state didn't give us, and we should be in our cells 22 hours a day. But basically, that's where my thought process went to. This has to be restored...

Classic theorizations of hunger strikes have depicted them as forms of pure bodily resistance or "weapon of last resort," (re)claiming ownership, control, and agency over the body as one of the few remaining tools that a disadvantaged person may have, resituating the subject's relationship to – and position within – larger institutional structures (Anderson 2010; Rhodes 2004; Sweeney 1993). Peter articulated some aspects of this narrative, to be sure, but his description of the rationale behind the hunger strike was also surprisingly legal. Thus, rather than an attempt at pure bodily sovereignty that remained incomprehensible to the state – a "life beyond utility" (Bataille 1991:198) – Peter's hunger strike relied on both the experience of control in embodied suffering and the systems of legal value and obligation the state had constructed in the law. In addition to incorporating schemes of juridical value over life and the quality of life that was afforded to him by the state, Peter also reminded me how the hunger strike was far from an isolated and self-contained event – that the act itself was intimately bound to the law and legal recognition:

Peter: It's kind of like.... I know that I can go on hunger strike at some point in time that will be less than a year, definitely less than a year, they would have to go get an intervention order from a judge allowing them to force feed me, alright? And I know they're *not* gonna wanna do that because they don't want some outside authority to start looking at them, and saying "Well why aren't you trying to resolve this? Why are you coming to me to get this order when you could have

resolved this at any time?” A competent judge, one who’s actually unbiased would tell the administration, “I’m giving you 48 hours to resolve this issue because if I have to sign this, I’m gonna open an investigation.” That’s part of my thought process with years under my belt in and out of the law library. Uh, going by civil action, either state – well state would be even longer – but federal, we’re talkin’ 5 or 6 years!

Nick: Oh, so it’s like maybe a more efficient way to bring it in front of a judge?

Peter: I’d be a more efficient way to bring it to a judge’s attention. My cousin made sure that there was an attorney around that had already filed a motion... when I was 20 days into it he had filed a motion with the present judge at Montgomery county, informing him that he wanted the court to keep an eye out for any motions, any petitions for an intervention order and to notify him so that he could be present to argue against it and bring the facts of the situation before the court. [...] So, like I said I just thought it would be the quickest, most efficient way of bringing attention, bringing a resolution. But I was actually, as I told my cousin, I’m actually willing to go out on this, you know? If I die, I die. At least all the pain is over with. The pain of all these years in here... at least it’ll be over with. She didn’t understand that. She just couldn’t understand how I’d be willing to do that. Look, I don’t want to put you through this, but it’s the truth. It’s how I feel.

Peter’s distinction between justice and the truth in his misconduct hearing paralleled his desires for the law to resolve his hunger strike, as well. It was not strict adherence to a given legal standard that Peter hoped would be recognized in the appeal, but that an “unbiased” judge would see both the rationality of his request and the suffering he had needlessly endured. In Chapter 3, I described how this kind of humanitarian investment in a bureaucratic system had the potential to be dangerous for medicine – that, especially when humanitarian intentions were not fully realized or not directly positioned against medicine’s own systemic forces of subjugation, those aspects of biopolitics that were most detrimental to inmates remained shielded behind humanism. Yet Peter relied on evoking sentiments that were just on the margins of what was expected from an institutional bureaucracy like the prison or the legal system that inmates relied upon and appealed to when seeking forms of legal recognition and justice. In short, they invested their appeals and strategic navigation of bureaucracy with a combination of

political gestures to rights and universal suffering in hopes that the system might recognize humanity and vulnerability within or despite the primacy of objectivity.

Continuing with a hypothetical scenario born out of a discussion with an administrator in which his hunger strike would have been seen before a judge or jury or if his requests were denied and he were to file a lawsuit, Peter outlined how the subjective experiences of suffering and appeals to rationality seep into the objective nature of the law:

I said [to prison administrator], “You know, if I have to sue you over this...” I said, “Put yourself on the jury in an objective fashion.”

[*Speaking to me*] You try this out. Make yourself a jury member and listen to a civil action lawsuit.

[*Takes on voice of someone presenting the case*] “Person’s on a hunger strike for the following reasons: He was wrongfully written up and convicted of a misconduct of an incident that he did not actually do, and you heard testimony from 30-40 people, admittedly all inmates, telling you the same story, most of which can’t even tell you this inmate’s name, they can only describe what happened to you, cuz they don’t really know him. The two guys that actually instigated the incident – one didn’t get wrote up at all and the other, his misconduct was dismissed, and we see no sanctions on him whatsoever. And that puts so much mental and emotional stress on the person and he felt that the only fight he could do was a hunger strike. Forty-one days endangering his health, endangering his life, losing 62 pounds because nobody wanted to listen to the facts. And you combine that, I mean you’re looking at security footage that shows you exactly step by step exactly what he’s saying the security office in his interview step by step, right? You’ve seen the statement of the accused inmate. You’ve seen the video footage – matches up perfectly. Yes, there’s no audio but it matches perfectly, give some credits to what he’s been sayin’, right? Then you look at the videotape of the closed-circuit disciplinary hearing with the hearing examiner where you’re looking at this guard sergeant’s face giving testimony listening to him saying, ‘Well he refused his tray and held the line up.’”

[*Now speaking as himself*] I’m like, “Oh, excuse me. Security cameras will prove that I not only took my tray, but I didn’t hold the line up. I went and sat down and the line continued to move after I took my tray and left.”

[*Back to presenting the case*] “And you look in this guy’s face, you can see that ...look in his eyes. Even though it’s on camera, you can see that this guy knows for a fact that he’s lying, and yet he’s lying. And then you’ve got a security examiner not paying attention to anything. They’re sitting there just scribbling on paper and *not* taking testimony down, just scribbling out. They’re already decided what they’re gonna do on the misconduct – guilty or not guilty – scribbling down sanctions and stuff. [...]

[*As himself, directed back at me*] And you're on the jury. You gonna decide for me or you gonna decide for them?

Seeking legal recognition in this way demonstrates how much Peter's claim relied on both objectivity and rationality, on the one hand, and compassion to vulnerability on the other hand. Affective attachment and personal investment in the law, as in medicine, is seen as something to be managed and disciplined as legal professionals are trained into objective legal reasoning (Mertz 2007). In Conley's linguistic work death penalty jurors, she shows how the language of the law, ways of talking about defendants, and receiving jury instructions are required to socialize jurors into legal decision-makers (Conley 2016). Katherine Culver (Culver, forthcoming) has described how members of criminal trial juries draw on discourses of objectivity in performing their civic roles despite the integration of their affective ties to the people and objects of the courtroom, their diverse political views, and their notions of common sense. As evidenced by Peter's account, inmates seeking recompense through the legal system must rely on judges and jurors performing this coded affect-work. They hopefully anticipate that formal and lay-participants will see – under the polysemy of objectivity – both the factual and objective aspects as well as the human and interpersonal dynamics that make up their legal claims. In fact, this kind of appeal to a layperson's sense of ethics and morality is encoded in the Eighth Amendment case law through the notion of “evolving standards of decency”¹¹ ultimately used to uphold – at least in theory – liberal humanist takes on punishment and cruelty. Peter's petitioning to these ideals is seen directly in his concurrent use of phrases like “an objective fashion,” “give some credits to what he's been sayin'” when objectivity breaks down, referencing mental and emotional stress, life-endangerment and encouraging a hypothetical juror to look into an officer's eyes to judge that “for a fact” he is lying.

Returning back to Peter's notion of justice rooted in the state upholding its obligations to him rather than the recognition of his innocence, his strike brilliantly appropriated the unfairness of his misconduct, the bodily agency of the hunger strike, and the power of the law. Drawing on the dynamics of property and the state-guaranteed quality of life that he was denied, Peter appropriated the language and priorities of a legal

system that supports the capitalist tendency to cast inmates as wards of the state – as themselves biological and financial property of the state – over the interests of disenfranchised and suffering inmates seeking justice. In a system where financial interests trump humanitarian concerns, the recognition of suffering and vulnerability, and the abstract notion of justice, drawing on the trope of property and state obligations appeals to those financial interests and serves as an ideal construct on which to base ones political demands.

Peter’s experiences also reiterate the kinds of connections between care and custody that are strongly cross-linked under the Eighth Amendment. The appeal to his life sentence on the grounds of cruel and unusual punishment is ironic in light of the starvation and malnutrition he was willing to put his body through under the watch of healthcare services that were bound to the same standard. Peter’s appeals to justice (both with his misconduct and his life sentence), while taking hold of his own bodily authority, still operated within the legal framework set forth by the Eighth Amendment. At every turn, Peter’s search for justice relied on him to demonstrate cruelty as justice’s opposite. My first interaction with him on clinical rounds demonstrates the objective standards that he faced in doing so, and how, in the case of his misconduct, the state’s legal obligations to avoid his death and to provide his housing and property rights superseded a humane response to suffering that was recognizable as such in the clinic.

In a surprising turn of events, the Supreme Court subsequently ruled in the 2016 case *Montgomery v. Louisiana* that its decision in *Miller* forbidding mandatory life sentences for juveniles would, in fact, retroactively apply the standard of cruel and unusual punishment those sentences issued before 2012.¹² *Montgomery* overrode the Supreme Court of Pennsylvania’s ruling to the contrary, and made Peter formally eligible for a new hearing that might result in his release on parole. As such, he remains the only one of my research participants serving a life sentence to face the real possibility of release, which will ultimately be based on the standard held in *Miller* to review individual circumstances and evaluate individual growth and change. While this standard may not even prove beneficial for Peter, especially given the misconduct that remains on his record, his race may favor such an interpretive framework. Historically, the criminal

justice system has allowed for shifting perceptions of white people as hard working and industrious and their crimes the byproduct of class relations and modes of production. In contrast, the standards of individual context and personal growth are rarely applied favorably to black appellants, who are unable to shake off the social stigma of criminality that has been so deeply, historically, and biologically racialized (see Muhammad 2010).

Roger

As I began to discuss in Chapter 1, Roger not only conceived of the delays in his lymphoma diagnosis as criminal negligence, but he also contended that the disease process itself was inextricably linked to the toxic prison environment in which he was knowingly put. To Roger, his illness therefore not only met the legal standard of “deliberate indifference” that qualified as cruel and unusual punishment, but it constituted murder at the hands of the state. Therefore, Roger conceived of his lymphoma as an additional way in which the state took his life (the others being his two life sentences), and his concept of justice in relation to these multiple life sentences was reconfigured in accordance with the value schemes that assigned dollar amounts both to his life and to the healthcare that the state was obligated to provide. Faced with the absurdity of serving two lives with a terminal diagnosis, Roger’s waiting had a defined end in death that was not marked by the ambiguity and uncertainty of release, but was characterized explicitly by the value he, fellow inmates, and his family accrued in that waiting.

As a paralegal, Roger was mindful of the legal avenues he had to seek justice for what he felt were criminal levels of negligence in the misdiagnosis and delays in care he faced. The skill and thoughtfulness with which he navigated the landscape laid out before him – but with heart-wrenching and tragic implications – necessitates a reworking of these actions outside of a theoretical framework that might conceive of justice within the legal system as the enactment of individual agency against structures of oppression, or as a means to a particular end. As will become apparent in his struggle, he was not a completely powerless victim of the legal structure. In fact, he moved about the legal landscape deftly, recognizing and utilizing the advantages it afforded. Nor, however, should his attempts at legal recognition and recompense be exalted as pure resistance

against oppression, because it is neither clear what forms of power he is resisting or what – if any – positive movement he is making toward liberation.

Roger’s dealings with the criminal justice system that led to his conviction and incarceration speak to the allure that justice has as a form of seeking truth and maintaining innocence. This allure is what kept many men waiting – both for health justice and justice in their convictions. This allure, the recognition of possibility amidst the confusing and arbitrary sovereignty of the law and the prison, drives demonstrations of vulnerability and suffering like those Peter outlined in his hypothetical scenario and makes them compelling avenues for seeking justice and recognition. For Roger, this allure motivated him to maintain his innocence in trial but led to a staggering reversal of fortune that gave him cause to reconfigure his expectations for justice. When he was in his twenties, Roger was an unarmed accomplice in a convenience store robbery that unexpectedly resulted in the murder of two employees. The District Attorney offered him a plea bargain of 5-10 years in exchange for providing more information on the killers and confessing to aggravated assault and robbery. Because he did not want to be implicated in another man’s conviction or confess to aspects of the crime he was not involved in, Roger decided not to take the plea bargain and instead saw his path to justice in “letting the truth prevail in court.” Unfortunately, things did not turn out as he expected:

I refused the deal, and my 5-10 turned into double life plus 27-and-a-half to 55. The other five unarmed accomplices, two didn’t get charged, one for 4-and-a-half to 10, he got paroled in ’94 or ’95, maxed out, never been in trouble with the law again. Another one got 5-10, he got paroled in the late ‘90s, and both their maximum sentences expired in 2001, which is when mine would have expired if I would have take the 5-10. But now I got 25 years in. I got that 5 years 5 times over.

In both trials (one for each murder) a jury found Roger guilty. In his first case he was found guilty of second-degree murder, and in the other case he was found guilty of felony murder as an accomplice. Dealing with this defeat, Roger retrospectively felt like his biggest mistake in that trial was not representing himself, at least in the second trial. In the first trial he remembered that the jury was not as convinced as he expected them to

be by the forensic evidence and surveillance footage that he felt clearly identified someone else as the murderer. Given this experience, he figured he could represent himself and instruct the jury better, appealing less to the “common sense” of the evidence and more to the “rules.” To his mind, the second jury needed to be well informed that the application of evidence in the case had to exceed the standard of reasonable doubt, that he as an unarmed accomplice who was not even in the store could not beyond a reasonable doubt be guilty of direct involvement in the crime that led to the murder. If he had represented himself, he figured he would be better able to use the rules in his favor, as a lesson learned.

In our very first interview, Roger was quick to outline for me the options as he saw them to hold the state accountable for providing ongoing treatment and to hold the state responsible for its role in causing and delaying the diagnosis of his lymphoma. It was clear to me that the thought process behind weighing his options was informed by the lesson of his trial. Rather than relying on evidence to do his work for him, or to assume that others in the position of arbitrating his claim would share his point of view or be sympathetic, he decided to work with the rules. In the case of seeking health justice, working with the rules ultimately involved the path of least resistance offered in the financial logics of care outlined in Chapter 1, where monetary compensation was the most logical and likely outcome of a lawsuit.

The first option Roger told me about was to pursue “compassionate release,” which is sometimes granted to inmates with terminal diagnoses, provided the inmate’s release to home or a medical institution does not pose “undue risk of escape or a danger to the community.”¹³ He confided that for someone who still maintains his sentence was unjust and wants desperately to be released from prison and to spend his remaining time with his family, I might find his decision not to pursue compassionate release contradictory. His rationale, however, was that if he filed for compassionate release, the financial burden for his chemotherapy would be placed on his family. He also cited the fact that he might die while waiting for an external lawyer to file for his release, which he mentioned would be more effective but more time consuming than if he were to file himself, as a reason for avoiding this option. Roger’s decision to remain incarcerated to

pursue chemotherapy highlights the fact that incarceration was the only way to guarantee he has access to treatment, demonstrating what he must endure in order to receive what limited positive rights to healthcare are afforded once the criterion of a serious medical need has been met and diagnosed.

Ultimately, staying in prison was a way for Roger both to guarantee that the prison fulfilled its obligation to care for him, and to prolong his life and spend that time with his family on visits. He also planned to use this time to assist other inmates in filing appeals to their convictions or lawsuits against the DOC who did not have his same level of legal training, in order to help them in their pursuits for justice. Roger justified his decision invoking the legal obligation cited in *Estelle v. Gamble* that the state “be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself,”¹⁴ claiming that they had agreed to take on the financial burden of caring for him when they sentenced him:

The thing is, when you gave me life, you said you was gonna take care of me for the rest of my life. Any time you wanna change the terms of that, we can change the sentence! If you don't wanna take care of me no more, change the sentence! I would just tell the court I would trade off, take the financial burden off the state, but I don't wanna put it on my kids and my family, for something that's gonna happen anyway, since it's terminal. I just wanna spend whatever I have left with my kids and my grandkids. So, I would make that tradeoff for that.

The second option Roger conveyed to me was to press criminal charges. Roger felt that his incarceration had directly caused his cancer because it exposed him to carcinogens in the air, water, and food supply. This thinking was inspired by toxicology reports conducted at other state facilities, most notably SCI Fayette, where cancer cases had increased among inmates and staff over the past decade and were correlated with increased amounts of toxic coal ash from a nearby dump site,¹⁵ and his extensive review of Graterford's water reports and packaging materials he found on products within the prison. Roger's murder accusation rested on the statute for first-degree murder in Pennsylvania, in which “premeditation” bears a strikingly similar degree of intent as the “deliberate indifference” clause from the Eighth Amendment litigation. Due to the

significant burden of proof placed on him to substantiate this claim and the notion that healthcare providers had acted with malicious intent to cause a disease as multifactorial as cancer, he felt like this option would be the least successful.

Outside of the burden of proof that the state's actions had directly and intentionally caused cancer, one of the other reasons this kind of litigation would have been unsuccessful was in defining exactly who is responsible, and if the state is responsible, who the state is. Roger would make claims like "They gave me cancer," "They took my life," and "They're committing murder." In those claims, the "they" he mentioned simultaneously referred to everyone and no one, highlighting the nebulousness of whom or what is the object of his accusations. His intention is to highlight the culpability of the state for placing him in the conditions of confinement that lead to his cancer, but how does one (and how could Roger) prove the deliberate indifference (read: intent) of the state? Even if he were to account for all the practitioners who acted negligently in his case, Roger recognized that this approach would also be unlikely to result in substantive change in prison healthcare practices. In fact, he reckoned, it might only encourage the withholding of diagnosis and documentation to evade culpability in an environment already pervaded with a "cover your own ass" mentality.

The final option Roger expressed to me (and the one he ultimately decided to pursue) was to assemble a wrongful death suit for his children to file after he dies. While somewhat unorthodox and of the least benefit to him directly, this option is in fact more commensurate with the economy of prison healthcare provision. Instead of a form of justice that resulted in his release or in structural change, Roger opted to seek monetary restitution for his family based on his own worth in death and the suffering he endured. He explained:

The wrongful death goes by the occupation that the prisoner had before he came to jail, how many more years he had on his life... bonuses, and stuff like that. Most prisoners didn't have an occupation when they came to jail, so the family would be lucky if they get \$30,000 for the prisoner. [...] Now, my wrongful death suit might be a little bit more because I'm a paralegal. The public defender association they told me that if I got commuted they would give me a job as a paralegal. [...] I have a whole bunch of skills that I didn't have when I was out

there. I used to be the secretary of the prison chapter of the NAACP, so I have organization experience, taking minutes, doing fundraisers and stuff like that. I have a whole lot of stuff that I can offer, so [...] it might be a little different with my wrongful death. And the way that I want to put it out there is they deliberately gave me cancer.

Thus there are two ways Roger had value in the economy of prison healthcare in which inmate-appellants were able to stake claims of justice. He had value to the healthcare vendor in being sick and untreated, and he had value to his family in death. The only form of value Roger had in being healthy was non-monetary – in his ability to continue visits with his family and assist other inmates with their legal cases. Even his rationale for his potential value outside of prison as a free citizen is meaningful and materially valuable only insofar as it holds the potential to garner more payout for the wrongful death suit. I want to be clear here that it was not Roger’s original or desired intent to pursue a wrongful death suit only to get money, as was a commonly held belief among healthcare practitioners for why inmates sue. Instead, this approach resulted from a careful analysis of his options and the conclusion that this was the most beneficial option for him and his family given the circumstances he found himself in.

Legal scholar Patricia Williams outlines how the infiltration of capitalist logics into rights discourse has limited rights protection to the restricted framework of contract law: “[T]he problem with rights discourse is not that the discourse is itself constricting, but that it exists in a constricted referential universe. The body of private laws epitomized by contract, including slave contracts, for example, is problematic not only because it endows certain parties with rights, but because it denies the object of contract any rights at all” (Williams 1987:424). In this case the obligation to protect against cruel and unusual punishment exists as a contract between the inmate and the state rather than as a right to timely and consistent access to healthcare. In a system where inmates’ rights are only understood and upheld on the basis of the idiom of ownership (or, more precisely, wardship), it makes sense that a framework for justice would not involve health, but compensation for death.

Later, Roger emphasized how little regard his life holds in this contractual framework and the double standard of assigning value and hoping for accountability in an inmates' rights framework:

I don't know if the public think we gettin' top-notch medical treatment. It's not so. And if they knew how their money was spent and about all the crazy stuff that goes on, they probably would be in an uproar. They probably would end up puttin' some of these people in jail. [...] Cause this right here, is murder. It's murder. It's a shame that it's murder and everybody turn their eye to it. Cause we people that people don't care nothing about. We society's throwaways.

As unsettling as it is that Roger's conception of justice relies on his death and the meager value assigned to his life in a wrongful death suit, it still demonstrates what Walter Benjamin, whose ideas I return to below, classifies as an act of "divine violence" under the law. Compared to the "mythical violence" of the state in its sovereign right to enact violence in order to take life, "divine violence" challenges the end justification of law to assert the irreducible value of humanity; "the first demands sacrifice, the second accepts it" (Benjamin 1978:297). Using the rules as he had learned to do, he ultimately did get to make a substantive claim to services in one of the only institutional settings where such a claim is even possible, and was able to both have his family avoid the financial cost of his care and even help provide for them after his eventual death. He drew the analogy to when he used to coach a football team: "When I was a coach I would tell my players, 'I can't give you heart. I can tell you how to play the game, but if you wasn't born with no heart, you ain't never gonna have no heart.'" Although he admitted that the form of justice he sought was not ideal, working within the circumstances he had available and "playing the game" was worth it to take that game to its logical conclusion and demonstrate that he still had "heart."

Eddie

Almost a month after meeting Eddie, he made a confession to me. I usually waited until inmates brought up their legal cases to me before discussing them. After getting to know me better, I felt like they would understand more why I would be interested in knowing details about their convictions. On occasion I broached too quickly,

or I would ask follow up questions immediately when someone would bring up their arrest, eliciting some initial discomfort and rebukes like, “Well, what does that have to do with healthcare?!” echoing some of the beliefs of the providers that the two really were separate or separable. For the most part, however, inmates’ legal cases were so much of what occupied their thoughts and activities in prison that it rarely took long for them to come up in conversation. I met Eddie early on in my fieldwork, and though he had already told me he was serving a life sentence, I had never asked him why, and it took a few weeks before it came up. That day he leaned in toward me, across the side of his infirmary bed he was sitting on and said, quietly and hesitantly, “You know... I’m in here for a murder, right? And you know something?” He paused for a while. I looked him in the eyes as my own eyes widened, genuinely not knowing whether or not the question was rhetorical. He continued, “I didn’t kill that man. Been here for 42 years, though. My life’s an open book. You can look up my case and see that I’m not making anything up.” He revealed this slowly because he knew (and told me so) how it could come off to profess one’s innocence, as yet another convict claiming he was framed – an evangelist for his innocence. In the same way that arguing one’s sanity tends to make one seem less sane, arguing for innocence in prison often made inmates seem less innocent.

In 1973 Eddie was at a pool hall in North Philadelphia, on the “wrong side” of the avenue that divided his neighborhood from an adjacent rival neighborhood. When gunshots were fired outside the pool hall, killing a man from the rival neighborhood, Eddie remembered knowing in his gut after all the frenzy subsided that he would go down for it because he “didn’t belong” in that neighborhood. Being an outsider who was there hanging out with some of his friends made him an automatic suspect. Furthermore, he had a prior conviction as an accessory to murder as a juvenile and was not a stranger to law enforcement. Another man from the rival neighborhood also later admitted to having been coerced under threat of accessory charges to name Eddie as the perpetrator to force a conviction, and Eddie was charged and then sentenced to life without parole. He had appealed his conviction once before, in the late 1990s, when a man made a confession to the same murder Eddie was convicted of before dying of AIDS. When the appeal made it to an evidentiary hearing, however, the deathbed confession was deemed

“against penal interest.” Because the man provided no other evidence of proof of his guilt beside the confession and it appeared that the man’s brother had not immediately come forward with the confession, the judiciary suggested that his confession could not be taken earnestly and was therefore inadmissible. The confessor had nothing to lose by making such a statement, and Eddie had everything to gain.

As the years passed and old neighborhood rivalries began to dissolve, more people in the community became outspoken about Eddie’s innocence. A few people had said that they were willing to testify, but not a lot of substantive evidence materialized beyond the deathbed confession that Eddie felt had been “wasted” in the evidentiary hearing, and Eddie continued to face upset after upset. One witness was pursuing a professional basketball career when he had heard the news of Eddie’s incarceration and had assumed he would be set free – that someone else would come forward with more information from that night. After returning to the community years later and finding out that Eddie had not in fact been released, the man began working with some of Eddie’s supporters to discuss how to best go about testifying, being careful to try and avoid any appearance that they might be conspiring on a false story. A few months later, the man died unexpectedly of sudden cardiac arrest.

In addition to losing ground against a growing standard of proof of innocence years after the murder, neither Eddie nor his friends and family members could afford to hire another lawyer to represent him in yet another appeal. Some pro bono legal and advocacy organizations like the Innocence Project would take up and drop his case, or else bury it in their caseload, initiating yet another waiting period. Together with small breaks and setbacks like finding and losing this witness, Eddie perpetually oscillated between optimism and depression. Faced with this long, often fruitless legal battle to overturn a wrongful conviction, Eddie’s concept and practice of justice operated by necessity on a number of different planes and timescales that reflected his tenacity under the conditions of hopeful (and at times, not-so-hopeful waiting). Some of these forms of justice relied on the mobilization and demonstration of the medical hardships that he had endured during his incarceration or acknowledging and soliciting the logics involved in the financial administration of care and custody in order to effect recognition. Others

involved a practice of cognitively and collectively working toward re-making the world to be a more just place.

Eddie described the concept of justice as it related to the way the criminal justice system was structured as a burden, as “a debt that has to be repaid to society that can never be repaid.” He connected this directly to the idea of belonging to the state as property via a literal financial debt that was being repaid through the kinds of capital extraction that went along with incarceration. Eddie cited exorbitant phone call rates, overpriced commissary items, medical copays, and then even attempting to support oneself after release as examples of the state exacting its payment of the debt associated with crime. “It’s hard. It feel like they tryin’ to... pile on, you know, everybody,” he said. “They say, ‘Beat the convict up. He no human being anyway. He deserve this, right?’ But my thing is, if you paid your debt to society – which you never do; there’s never a end result, cuz you got that on you for the rest of your life. And guys is finding it real hard.”

Having the burden of this un-payable debt made seeking a form of justice that was based in its repayment an impossible task. Punishment could never be exercised in a way that was commensurate with a crime given this type of framework, and similarly, Eddie would never realize a form of justice that was commensurate with the burden the state had in repaying him for the hardships he had endured beyond what he thought could repay his assumed debt to society. As an alternate way of attempting to make peace with this burden, Eddie went on to discuss karma as a potential framework for justice. He thought perhaps that he was being cosmically punished for his past offenses as a juvenile – a punishment that extended even to his medical problems. In this framework, however, the scales tipped too far in the other direction. The more hardships began to pile up and the longer his incarceration went on, the more unfair his situation seemed:

After all these blows I took, mom and pop gone, my leg gone, this gone, I need me some good news! I think it’s about time for me to get the fortune, for the ball the roll the other way! [...] And like... one of the things that keep me going, not that I don’t believe in poetic justice. At one time I was saying it to myself to keep myself sane. But I don’t want poetic justice. I want the real thing! To hell with poetic justice! I did a lot of things in my past, as a juvenile. I was thinking maybe it was that catching up to me. But to hell with that. I done answered for what I did back then.

Previously, Eddie had told me about the ways he imagined freedom in the prison without having the ultimate freedom of being released – how he could “escape” through a book, through prayer, through meditation, and forget for a period of time that he was incarcerated. When I asked him if he had a similar way of imagining justice short of the justice of overturning his conviction, his immediate response was to mention how he would think of things “out in society” that were perhaps more unjust than what he had to endure, reorienting justice as something that belonged to other people and not to himself.

Nick: What about for yourself?

Eddie: [pause] In my, um, *formative* years they said I had a smart mouth, because I would say certain things that I would believe in. I wouldn't give myself over to them. To this day, you have guys say, “Look at my house such and such...” They talking about their cell! But I never call it my house. I never called it a bed, I called it a bunk. See, I've been in a bed before. I know what a bed is. That's not it! It's not a bed. So there's little things that I do to fight being institutionalized. And it's a constant battle. You can't give up because just when you think you're there – that I've been here this long, and I understand the psychological effects that these things have, and I know this right here, now I don't have to be vigilant all the time because I know I can't be institutionalized. I think *that's* when you're the most vulnerable... of *being* institutionalized, when you let down your guard.

One time this guard came at me, “Where you live at?!” I said, “2065 North 16th Street.” He said, “What?” I said “2065 North 16th Street. That's where I live.” He said, “No, I'm not talking about where you live out on the street. What block are you on?” I said, “Well, I'm on C Block. You should have asked that. I don't live here, I'm a prisoner.” And I look at him like that [*nods his head smugly*] and they, sometimes, *because* I look at 'em like that, they take it as me being smart. So I'm talking about giving into those things. I just don't give over to it. It's my way of fighting against being institutionalized. Especially if I believe it's unjust. I'm gonna come in here, give myself over to this place *and* it's unjust, too? No. This is my way of fighting back without actually, physically fighting back. It's resisting from giving myself over to this situation.

Resisting institutionalization in this way was one of the more cunning ways Eddie was able to practice a form of justice strictly defined in opposition to the way the prison world was structured to be un-just. He was able to wield the interpretive power of language and recontextualize meaning and relate it to the material structure of the prison

and the experience of incarceration. Changing what those words meant to him remade the material world around him and allowed Eddie to avoid some of the more dehumanizing aspects of institutionalization. He was also one of the few inmates I met who consistently used the word “convict” to refer to himself instead of inmate or prisoner, because he felt it more accurately reflected his reality. He had been convicted of a crime (but was not necessarily guilty) and did not want to associate with the connotations of captivity that “inmate” carried with it.

In addition to these more quotidian approaches to justice outside of the legal system, Eddie worked collectively on legislative reform with Graterford’s chapter of the Gray Panthers, a group founded in Pennsylvania in the 1970s to advocate for the rights of senior citizens, which were then primarily centered on the forced retirement of seniors and poor conditions within retirement homes. The Graterford chapter was committed to pursuing “age out” legislation that limited sentences to 30 years and made all inmates older than 50 eligible for release. In this case, Eddie was able to work collectively toward a standard of justice that stood to benefit him and many other aging people serving life sentences. Relating back to the notion of debt that Eddie raised, the argument the Gray Panthers laid out shifted the overwhelming debt inmates were expected to pay onto the financial obligation of the institution to care for inmates. The following is an excerpt from their mission statement that Eddie delivered to me:

Aging out legislation is needed in Pennsylvania for practical and for compassionate reasoning. First, practical reasoning is easy for rational people to get. The dollars and sense of it all. It now costs \$62,000.000 per year to house an aging prisoner. Compare that to prisoners who are not 50 yet. Those figures are closer to \$35,000.00 per year per prisoner. The costs nearly cut in half of what it now cost to keep older prisoners. So why continue spending so unwisely? [...]

Corrections has little to do with successful re-entry past age 50. For aging prisoners over age 50 the recidivism rate is below 1 percent. Aging prisoners don’t want to be a burden to this Commonwealth. Most elderly prisoners are in prison for a one time act long ago. And because of their age are not likely to repeat their actions so long ago. Most elderly prisoners are truely [sic] repentant for their actions and made a consorted [sic] effort to become role models and leaders among their peer prison communities. [...] Many are civic minded citizens that would want a second chance to live out the remainder of their lives with what loved ones they have left.

In this statement they invoke the exorbitant cost not only to house inmates, but to pay for the increased healthcare needs of elderly inmates as justification to support age out legislation, merging both administrative/bureaucratic and humanitarian rationales – “dollars and sense” – in similar ways to the logics around Peter’s imagined scenario and argument for his hunger strike. They draw out and rely on compassion within the bureaucracy of legislature while also catering to the more impersonal, financial logics that affect that bureaucracy’s “bottom line.”

Against the horizon of his wrongful conviction appeal, Eddie’s concept of justice for his broader legal battle rested in the possibilities of care emanating from outside the prison’s walls. He relied on the efforts taking place in his community to bring recognition to his case, elicit more witness testimony, and raise legal fees. His childhood friend Diana organized many of those efforts and held community fundraising events like raffles and barbecues. His friends and family members also recruited me, as someone with the cultural and financial capital to own and work on a computer regularly, to assist them with setting up crowdsourced fundraising pages on websites like Go Fund Me and Funded Justice. Diana also wrote a letter to President Obama seeking support and a commutation of Eddie’s sentence. Although Obama commuted over 1,000 prisoners’ sentences during his time in office, all of them were for non-violent drug offenses, and few resulted in actual pardons, so that letter bore no results.¹⁶

In the letters and websites, Eddie and his supporters relied on conveying hardships that he had faced both personally and medically to garner support. They described the time lost with his family including his children and the poor medical care that resulted in his amputations as both justification of a sacrificial punishment that he had endured – that he had “been through enough” – as repayment of his debt to society and as a rationale for demonstrating the lack of threat that he would pose as a former convict returning to the community. As I mentioned in Chapter 3, Eddie rationalized his disability as reason enough to convince a judge that he no longer posed a threat to society: “A judge would have to see what’s left of me and say, ‘Time served!’ A judge just has to look at me. I’m old now, and only one leg. What am I gonna do? I can’t run

around committing crimes on one leg! C'mon now! *It's got to be time served.*" Eddie also distinguished himself from some of the logics that Roger drew on that conceived of justice in the form of monetary compensation both because it aligned with how literal value was assigned to the administration of healthcare in prison and because it was the most easily obtainable form of legal remedy within the legal infrastructure built around inmates' right to healthcare. Eddie rejected the idea that legal justice for him involved remuneration, or that he was owed something for either the wrongful conviction or medical negligence. Instead, the limit of legal justice existed in overturning his wrongful conviction.

Nick: I'm just wondering if there's a – if you also felt like there's something that you're owed, in a sense, because of all that's happened.

Eddie: No. I'm not talkin' about, I'm not even *thinking* about no money. I'll even promise them I won't sue if it means I can get outta here! All I'm thinking on about is coming home and spending the rest of my life out there in society.

Not only did Eddie not subscribe to the notion that justice involved a form of state payout, recalling his earlier comments about debts owed, but he set up an active bargain in order to position himself (and the ultimate justice he sought) against such an idea. He was willing to demonstrate to the state that he was not the kind of inmate who was interested money, or who placed a higher value on freedom. In that sense being compelled by the allure of justice and the truth it represented was something that he and Roger shared, at least before Roger's trial revealed that to be a fiction.

From the daily ways that he resisted institutionalization to the joint efforts with his communities and the organizations in prison, Eddie worked to materialize distinct and diverse forms of justice. As he looked toward the horizon of an increasingly unlikely exoneration, these alternative projects of justice-making worked at different points along the trajectory toward that horizon as well as inside and outside the legal infrastructure of inmates' rights. The different planes along which justice operated for Eddie constitute different paths or "lines of flight" for justice.¹⁷ Some of his projects created appeals to the financial regulation of inmates' healthcare and valorized his own suffering as justification

for release, reproducing or even exacerbating the violence of the law in financially regulating inmate healthcare. It was the diversity of his justice-making projects and the creative reassembling of logics of care, value, debt, and justice that they entailed that gave Eddie confidence in his efforts and allowed them to fulfill various, distinct roles for him during this anxious and tumultuous period of waiting for an appeal.

“Perhaps” as Political Praxis

Inmates’ projects of realizing justice relied on a sense of “cruel optimism,” which Lauren Berlant ascribes to relationships people have to the objects of their desire that ironically inhibit them from thriving and flourishing under contemporary capitalism (2011). In order to survive the daily burdens of life under cruel optimism, subjects come to rely more on the relationships that they build with the objects of their desire rather than the objects themselves. In this case, it was not merely maintaining a relationship with the abstract notion of justice that allowed inmates to endure suffering and injustice; it was also what kept them waiting for justice. During the process of waiting, they were able to reconceptualize what justice might mean and realize how it might be provisionally actualized. Despite not overcoming cruel optimism, inmates were still able to make material gains that could be counterbalanced against the losses that they endured. Building connections and relationships to the law while waiting was therefore encouraging and disheartening, enabling and disabling.

Peter, Roger, and Eddie all relied on the suffering that they endured while waiting to also make justice, and sometimes even ironically actively pursued or exacerbated that suffering, putting their bodies and lives in danger in the name of life itself. Whether it was Peter starving himself for his quality of life, Roger remaining imprisoned to pursue chemotherapy, or Eddie casting himself as a burden to argue for his release, these actions often exceeded the judicial measures of justice and undermined the sovereign power to regulate, control, or take life. As I have shown, however, it would be myopic to understand them as acts of embodied opposition to sovereignty. Instead they must also be appreciated within their larger juridical contexts in order to acknowledge how they take advantage of the capacities of the law.

Walter Benjamin's "Critique of Violence" and Jacques Derrida's "Force of Law" both deal with the notion of justice with respect to the violence of the law, providing some insight into the questions with which I opened this chapter. They too are driven to consider if the law, which is rooted in the violence of sovereign control and the ability to make and remake itself, can be seen as upholding justice. Based on a consideration of the ends that use violence as a means, Benjamin draws a distinction between the mythical violence of the law and divine violence that undermines it. Mythical violence uses force as a means to institute and preserve order, and then to obscure itself so that the authority of the state seems self-evident. For Benjamin, making demands of the state (e.g. for punishment and suppression of others or the privileging of oneself) recapitulates this violence inherent in the law. In a way similar to Eddie's description of the burden of repayment, this kind of violence exacts a toll on those who suffer from the actions required to enact it. Divine violence, on the other hand, exists as "pure means" and makes no demands other than those rooted in "the condition of man," which Benjamin takes as the basis for justice. "Justice," he writes, "is the principle of all divine end making, power the principle of all mythical lawmaking" (Benjamin 1978:295).

Drawing on Benjamin's discussion of violence, Derrida extends it in order to erase the distinction Benjamin makes between mythical and divine violence instead concluding that all acts that require force to be enacted or maintained reinstate law-making violence. Thus, Derrida has a much more pessimistic view for the possibilities of justice under a system that reinforces violence against others. His critique of Benjamin is appreciated in the more narrow view of the struggles for justice attempted by Peter, Roger, and Eddie in which even provisional forms of justice came at a substantial monetary and bodily cost. At the same time, focusing on the immediate consequences and the justice denied to them precludes an appreciation of the ways Peter, Roger, and Eddie make meaning in justice. Regaining property, extending life, and resisting institutionalization while raising money for an appeal were significant ways that this violence was offset.

In this way, Derrida is forced to see justice as only truly existing in its potentiality. Justice itself is something that "doesn't wait. It is that which must not wait"

(Derrida 1992:26) because just decisions must be made in moments of urgency. In this urgency, however, justice becomes overly performative and gets “ahead of itself,” being enacted and justified for things still to happen in the future. This meant that, though justice does not wait, it can only exist for those it serves as something *à venir* (yet to come) – something that we must, in fact, wait for. It is through inhabiting this potential and living in its contradictions where Peter, Roger, Eddie, and other inmates discovered that, rather than existing as an unobtainable horizon, justice “has no horizon or expectation” (27) except the one that they constructed for themselves. Derrida writes: “That justice exceeds law and calculation, that the unrepresentable exceeds the determinable cannot and should not serve as an alibi for staying out of juridico-political battles, within an institution or a state or between institutions or states and others. [...] Incalculable justice *requires* us to calculate” (1992). Thus, it was only in waiting for justice that inmates were able to find it both within and without the structure of law and rights. “Perhaps it is for this reason that justice, insofar as it is not only a juridical or political concept, opens up for *l’avenir*, the transformation, the recasting or refounding of law and politics. ‘Perhaps,’ one must always say perhaps for justice” (27).

¹ Although it describes racial injustice as a sort of de facto result of the political processes that led to mass incarceration rather than as strong, central motivator of them, William Stuntz’s historical analysis of the centralization of the criminal justice system demonstrates that the politics of crime led to the uncoupling of punishment from crime that allowed the system to “run off the rails” through formal legal procedures that were in theory meant to reduce bias and promote justice (2011:5).

² See also Auyero’s (2012) discussion of waiting for state medical services in Argentina, where claimants adopt a subjectivity in response to performing the labor of waiting.

³ Prealbumin is a protein made in the liver and present in the bloodstream. Its presence is affected by the ability of the body to synthesize new proteins, and is therefore sometimes used as a nutritional marker, though see footnote 4.

⁴ See, for example (Lee et al. 2015). Often the body reacts to inflammation, infection, and other disease states by producing less prealbumin. It has been suggested that prealbumin can be more effectively used as a marker for patients who are at risk of being malnourished, rather than as a marker of nutritional status (Shenkin 2006).

⁵ Pennsylvania is notorious for dysfunction and corruption in its juvenile criminal justice system, most notably the “kids for cash” scandal of the 2000s, when a county judge was revealed to be taking bribes to inflict harsh sentences on juveniles and sentenced over 2,000 young people to time in detention facilities, usually for minor offenses.

⁶ Interestingly these points were made in distinction to adults, who were assumed to have a fully-formed sense of morality, making them therefore entirely culpable for their actions, and to not be

capable of the kinds of change that would warrant a parole hearing for offenses that would warrant a life without parole sentence for an adult. Citing a prior case that determined life without parole sentences were unconstitutional for juveniles convicted of non-homicidal cases, the Court states: “children are constitutionally different from adults for purposes of sentencing. Because juveniles have diminished culpability and greater prospects for reform, we explained, ‘they are less deserving of the most severe punishments’ (*Graham v. Florida*, 130 US 2011 [2010] at 2026)” (*Miller v. Alabama*, 132 US 2455 [2012] at 2464).

⁷ Brett Hambright, “New law gives Lancaster County judges discretion in sentencing juvenile killers,” *Lancaster New Era Online*, November 4, 2012, http://lancasteronline.com/news/new-law-gives-lancaster-county-judges-discretion-in-sentencing-juvenile/article_8de7d9c9-26d3-5031-a0e5-1acd0e6ac6b7.html.

⁸ “Juvenile Life Without Parole (JLWOP) in Pennsylvania,” *Juvenile Law Center*, accessed November 25, 2016, <http://jlc.org/current-initiatives/promoting-fairness-courts/juvenile-life-without-parole/jlwop-pennsylvania>.

⁹ In this case, the Pennsylvania supreme court decided that there were no grounds for retroactively applying the decision in *Miller*, and that the “claim must be decided under the law as it stood at the time his conviction became final” (*Commonwealth v. Cunningham*, 81 A. 3d 1 - Pa: Supreme Court [2013] at 7-8). The decision further classified the appellant’s claim to retroactive application based on some of the logistical details of the *Miller* case and prevailing legal standards to be “tantamount to an exercise in ‘word games’” (Ibid. at 7).

¹⁰ As evidence of this, Peter cited another lawsuit that the Department of Corrections lost against an inmate with whom he shared a cell in violation of his single cell code. After Peter had a panic attack, which he said was a result of a fear and anxiety of being attacked himself in his sleep, he beat up his cellmate. The man sued as a result and won \$25,000 in compensatory damages.

¹¹ “The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society” (*Trop v. Dulles*, 356 US 86 [1958] at 101).

¹² *Montgomery v. Louisiana*, 136 S. Ct. 718 [2016].

¹³ According to Title 42 of the Pennsylvania Code, “Judiciary and Judicial Procedures” (42 Pa. C.S. § 9777 (a)(1)(v) and (a)(2)(iv)).

¹⁴ *Spicer v. Williamson*, 191 N. C. 487 [1926] at 7, cited in *Estelle v. Gamble*, 429 US 97 [1976] at 104.

¹⁵ An independent toxicology report and review of medical and mortality data conducted by the Abolitionist Law Center and the Human Rights Coalition at SCI Fayette in Pennsylvania discovered that toxic coal waste near the facility was directly related to an increase in respiratory symptoms, skin conditions, gastrointestinal problems, and both diagnosed cancers and undiagnosed tumors or lumps (McDaniel et al. 2014). An internal review done by the Department of Corrections found “no scientific data to support claims of any unsafe environmental conditions or any related medical issues to exist at SCI Fayette” (DOC Press Release, December 31, 2014). The ALC and HRC report cites health as a “human right,” and acknowledges that a poor healthcare response to environmental toxic exposure can only be deemed “cruel and unusual” after the threat becomes known and healthcare providers act deliberately to deny care despite their knowledge of harm. It ends with a call for health monitoring and tracking and for the legal community to investigate into potential legal action and the closure of SCI Fayette. Since the report was issued, it was rumored that a few correctional officers who suffered ill effects from the exposure were planning on filing a lawsuit but were discouraged from doing so by their union. Consequently, no lawsuit from either correctional staff or inmates has emerged directly related to the report’s findings, and inmates continue to be incarcerated at SCI Fayette.

¹⁶ Juleyka Lantigua-Williams, “President Obama Hits Another Commutation Milestone,” *The Atlantic*, November 22, 2016, <http://www.theatlantic.com/politics/archive/2016/11/obama-commutations-record/508538/>. George Lardner Jr. and P.S. Ruckman Jr., “On pardons, Obama could go down as one of the most merciless presidents in history,” *The Washington Post*, March 25, 2016, https://www.washingtonpost.com/opinions/obamas-unpardonable-inaction-on-pardons/2016/03/25/dfe670a8-f07a-11e5-a61f-e9c95c06edca_story.html?utm_term=.7921c3d69c9f.

¹⁷ See Deleuze and Guattari’s discussion of the rhizome as a method of psychoanalytical and political praxis, making use of the multiplicities of desire, language, state ideology, etc.: “Drives and part-objects are neither stages on a genetic axis nor positions in a deep structure; they are political options for problems, they are entryways and exits [...]”(1987:13).

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