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Essay/Personal Reflection

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Despite international recognition of the importance of palliative care as a shared universal right (Henteleff et al. 2011), a health equity gap exists between Canada's general and carceral populations (Linder and Meyers 2007). Incarcerated people face unparalleled health inequities before, during, and post-incarceration (Brinkley-Rubinstein 2013). While the nursing discipline made advances in recognizing the detrimental effects of social determinants on health, the specifics of inequalities faced by terminally ill prisoners remain hidden from the public view (Brinkley-Rubinstein 2013). In addition, the public and health-care providers often impart judgment on prisoners and regard such individuals as unworthy of equitable health care (Song et al. 2007). The following discussion aims to explore death in prison from the social justice perspective by articulating philosophical, social, and spatial dimensions that underpin end-of-life experiences for incarcerated individuals, hoping to inspire the possibility that life can be different.

Equity-informed lens

When I contemplate whether dying in prison without access to quality palliative care is inequitable, I am attempting to understand the concept of inequity in a broader sense and in relation to health and health care. Significant differences in health outcomes exist across countries and between various groups within countries; however, not all differences correspond to inequities (Whitehead 1992). Steeped in ethical, moral, and social meaning, “inequity” refers to variations in health status that are socially modulated and have little to do with one's biological aspects of health (Reimer-Kirkham et al. 2016; Whitehead 1992). Unlike predetermined genetic and biological variations, health inequities are deemed unnecessary and unjust because they stem from contextual social conditions in which groups within the lowest social gradient are systemically disadvantaged (Whitehead 1992). These disadvantages are avoidable and include a range of adverse risk factors such as inadequate housing, lack of means to support a healthy diet, or barriers to accessing basic health services (Whitehead 1992).

Certain populations experience pervasive inequities across multiple life domains that profoundly influence their health trajectories and end-of-life experiences (Reimer-Kirkham et al. 2016). Disproportional obstacles to quality palliative care are stacked against those who experience homelessness, poverty, racism, mental illness, and other socioeconomic conditions imbued with inadequate determinants of health (Reimer-Kirkham et al. 2016). More recently, a concept of “doubly vulnerable” was introduced in equity-informed literature that describes individuals whose palliative care needs intersect with significant social barriers and other nexuses of dominant hierarchies where the needs of marginalized groups are disregarded (Reimer-Kirkham et al. 2016, 294). Among such groups are carceral populations. Relevant to prisoners, Turner et al. (2018, p.162) introduce a concept of “double burden,” an understanding that some people face health disparities in addition to the loss of liberty. For individuals of advanced age, it can also mean an unintended life sentence due to a high likelihood of dying in prison (Turner et al. 2018).

Dimensions of inequity

Overall, the concept of inequity is notoriously difficult to encapsulate as it traverses multiple disciplines and theoretical perspectives with divergent interpretations and utilizations (Reimer-Kirkham et al. 2016). It is also complex and multifaceted, encompassing both practical and abstract elements. To ground inequity in a more pragmatic realm vis-à-vis prisons, I propose 2 comparable terms with distinct contextual differences: “a constellation of burdens” and “a constellation of barriers”. The *constellation of burdens* refers to an intersection of all inequities each incarcerated individual faces. This constellation is unique, specific, and individualized. For example, a prisoner may have a terminal diagnosis, live with a chronic health condition, have no family outside of prison, and identify as queer. On the contrary, the *constellation of barriers* refers to a set of shared obstacles encountered by all the

prisoners. For instance, a carceral environment and laws regulating compassionate release and palliative care access would constitute these barriers. The compounding effects of both constellations are egregious.

In the book *Punished for Aging*, Iftene (2019) presents a compelling and heart-wrenching description of realities in Canadian penitentiaries that exemplify the dimensions of inequity described above. With careful precision and vivid detail, the author threads stories of older prisoners who report limited access to health-care staff, lack of specialized care and medical devices, outdated facilities not designed to accommodate mobility impairments, overcrowding, double-bunking, lack of incontinence products, safety concerns associated with physical decline, and barriers to family involvement (Iftene 2019). An 82-year-old male with diabetes, chronic pain due to advanced arthritis, and urinary incontinence reported frequent falls due to multiple staircases, top bunk sleeping arrangements, and a lack of handicap railings in showers. He was also afraid of soiling himself in front of other prisoners (Iftene 2019).

A clear demarcation of inequities between individual and collective dimensions has practical implications for addressing the palliative care needs of the incarcerated population. Understanding the contrast between cumulative personal and general constraints as experienced by prisoners who require palliative care exposes multiple levels of health inequities and creates possibilities for individual and policy-level approaches to this issue. Expanding on the notions of doubly vulnerable, as explained by Reimer-Kirkham et al. (2016) and the double burden, as discussed by Turner et al. (2018), the *dimensions of inequity* underscore similar intersecting complexities for the prison population.

Background

A total of 37,932 individuals were in custody in Canadian federal and provincial correctional facilities in 2018–2019 (Public Safety Canada 2022). In 2019, over 3,000 federally incarcerated individuals were 50 years old and above, comprising 25% of the federal prison population (Office of the Correctional Investigator & Canadian Human Rights Commission, 2019). Older adults are also overrepresented in federal custody in comparison to the general population, and this gradual upward aging trend is expected to continue (Office of the Correctional Investigator & Canadian Human Rights Commission 2019). Office of the Correctional Investigator Canada & Canadian Human Rights Commission (2019) identified 3 key factors contributing to the increase of older adults in federal custody: long sentences, life or undetermined sentences, and sentences for historic offences. In addition, the ethnic profiles of prisoners expose social forces that contribute to health inequity inside the prisons (Office of the Correctional Investigator, 2014). For example, 28% of federal prisoners are Indigenous, and 9.2% are Black Canadians, while only 4% and 3.5%, respectively, of these ethnic minorities comprise the Canadian population (Office of the Correctional Investigator, 2022). The compounding effects of these and other criminal justice policies mean that more individuals will experience aging, illness, bereavement, and death behind bars (Iftene 2019). Between 2018 and 2019, 51 individuals died in Canadian federal prisons, and approximately 70% were attributed to natural causes (Office of the Correctional Investigator, 2019).

A brief sketch of prisoners' health

Due to disproportionately large numbers of socially disadvantaged individuals in prisons, their health needs are complex,

compounded and neglected (Office of the Correctional Investigator & Canadian Human Rights Commission 2019). Many individuals in custody live with multiple comorbidities and chronic illnesses due to poverty, homelessness, and lack of food security prior to incarceration (Office of the Correctional Investigator & Canadian Human Rights Commission 2019). The Report of Ontario's Expert Advisory Committee on Healthcare Transformations in Corrections (2019) states that incarcerated individuals "are three times more likely to have a mental illness or experience problematic substance use" (p. 8). Poor health of prisoners is often entrenched in previous experiences of colonialism, racism, abuse, poverty, and violence, with vast differences between the overall health of incarcerated individuals and their counterparts in the general population (Bedard et al. 2017; Office of the Correctional Investigator & Canadian Human Rights Commission 2019). Specific adverse factors include family violence, childhood abuse, housing insecurity, lack of education, low-income status, high prevalence of mental health disorders, high rates of suicide, alcohol and drug use, increased exposure to communicable diseases, high-risk sexual behaviors, and physical injuries (Kouyoumdjian et al. 2016). People who experience incarceration bear an unequal burden of illness significantly exacerbated by the lack of access to primary care settings such as family doctors and clinics before and post-incarceration due to stigma, discrimination, and mistrust in the health-care system (Office of the Correctional Investigator & Canadian Human Rights Commission 2019).

Women, whose admission to Canadian federal prisons increased from 170 in 1990–1991 to 562 in 2019–2020, have particularly unique and challenging needs (Office of the Correctional Investigator 2019, 2022). Research conducted with incarcerated women revealed that many are from Indigenous backgrounds, have engaged in previous suicidal behaviors, and have lived through a traumatic event (Office of the Correctional Investigator 2019). Most concerning, half of all federally incarcerated women in Canada are Indigenous (Office of the Correctional Investigator 2022).

Overrepresentation of Indigenous and Black people in Canadian Prisons

The most recent report from the Office of the Correctional Investigator (2021–2022) identified 4 main issues related to conditions in Canadian prisons: the overrepresentation of Indigenous people, the overrepresentation of Black people, outdated drug policies, and the use of solitary confinement. While all 4 concerns are troubling and negatively impact the lives of incarcerated individuals, the overrepresentation of Indigenous and Black people requires special scrutiny. Mirroring the inequities embedded in the societal landscape, the treatment of individuals "who are economically exploited, politically subordinated, or socially excluded" (Reimer-Kirkham et al. 2016, 295) outside prisons leads to the overrepresentation of marginalized groups within them. For example, the overall federal carceral population decreased by 16% in the last 10 years; however, the number of incarcerated Indigenous people increased by 22% in the same period (Office of the Correctional Investigator 2022). This ethnic overrepresentation also extends to maximum security placements, segregation, disciplinary approaches, and use of force incidents (Office of the Correctional Investigator 2022). Despite the appointed role of Correctional Services Canada (CSC) to rehabilitate and reintegrate prisoners back into communities, their policies perpetuate the

cycle of reoffending by failing to provide culturally appropriate mental health services, programming, and effective drug strategies such as safe needle exchange and harm reduction measures (Office of the Correctional Investigator 2022). For Indigenous and Black people, these shortcomings are part and parcel of colonial policies.

The effects of colonization are detrimental and profound. They permeate all social, public, political, economic, and cultural spheres and perpetuate inequities across these domains. In Canada, prisons are one area where the effects of colonizing policies continue to reverberate undisturbed (Tetrault 2022). Indigenous people are excessively overrepresented in federal and provincial prisons, constituting 28% of the Canadian carceral population while accounting for only 5% of the general adult population (Tetrault 2022). This problem is not unique to Canada, and similar concerning statistics are reported in the United States, New Zealand, and Australia (Tetrault 2022). Moreover, such overrepresentation is unequal across genders, with Indigenous women bearing a higher cost (Tetrault 2022). In Canadian provincial prisons, Indigenous women account for 43% of the carceral population compared to 26% of Indigenous men (Tetrault 2022). Colonialism, systemic discrimination, victimization, and culture clash are among a few reasons why Indigenous women are overrepresented in the Canadian criminal justice system to such a great extent (Clark 2019). Acting in concert, these issues create a cycle of victimization and offending for Indigenous women, who are often charged with crimes at either end of this spectrum (Holmes 2017).

Current state of palliative care in correctional settings across Canada and Abroad

“Prison is an unsuitable place for an individual who requires end-of-life care” (Office of the Correctional Investigator 2019, 11). This sentiment articulated by the Office of Correctional Investigator (2019) in the recent report emphasizes fundamental ethical concerns and obligations, the fulfillment of which is crucial for protecting inherent human rights and dignity. Similar views are expressed by numerous individuals in custody who report the fear of dying within the confinements of prisons (Office of the Correctional Investigator 2019). Handtke and Wangmo (2014) point out that physical palliative symptoms such as pain, respiratory distress, and altered level of consciousness are only one part of the complex and multifaceted aspects that require attention and management at the end of life. To address the psychological, cultural, and spiritual needs of terminally ill prisoners and provide care in accordance with the “whole person” approach rooted in palliative care philosophy, additional provisions might include family support, bereavement, and legal services (Office of the Correctional Investigator 2019; WHO, n.d.; Hudson et al. 2019).

Currently, palliative and end-of-life care for older prisoners in Canadian federal prisons falls within the responsibilities of CSC, which, in turn, is not designed or equipped to provide such care (Office of the Correctional Investigator 2019). In one case example, CSC attempted to place a 64-year-old incarcerated man with dementia into long-term care. However, this man lost his placement due to the procedural bureaucracy, inflexibility of the parole board, and his mental health state (Office of the Correctional Investigator 2019).

In contrast, in the United States, medical and geriatric parole models exist to streamline the release of low-risk terminally ill prisoners into the community (Office of the Correctional Investigator 2019). Palliative care units have been established within the correctional system to provide quality end-of-life care

with community partnerships and peer volunteers (Office of the Correctional Investigator 2019). For example, Louisiana’s Angola Prison partnered with a local hospice to provide symptom management and palliative care using a collaborative interdisciplinary team model to provide care to prisoners who cannot be released into the community (Handtke and Wangmo 2014). Although some strides have been made to advance the provision of palliative care for incarcerated individuals, many countries around the world, including Canada and the United States, lag in recognizing, establishing, and streamlining access to equitable palliative care within and outside the correctional settings (Bedard et al. 2017). In the meantime, harsh judicial sentencing and rigid compassionate release regulations in Canada mean that countless aging prisoners who pose minimal risk to public safety will experience undue suffering and isolation at the end of life (Office of the Correctional Investigator 2019).

Philosophical dimension

Death is an unescapable part of life, and the experience of dying is both individual and universal. The concept of *dignity in death* is central to many cultures globally and rooted in philosophical, social, geographic, and religious elements. Defining *dignity* can also serve as an entry point to talk about death from a social justice perspective and begin to form an understanding of inequities in end-of-life experiences. However, untethered from moral, philosophical, and epistemological aspects, *dignity in dying* loses its potential to mobilize public support and influence policy development, especially for incarcerated people. My goal is to add clarity to the concept of dignity. Moreover, later in this section, I highlight how the conceptualization of *human beings* and their *bodies* in the mainstream Western philosophical traditions is consequential for prisoners and propose to interfere with such discourse. I problematize the *human body* as conceived in the carceral system and advocate for a distinctly transformative model, drawing on ideas put forth by Dutch ethnographer and philosopher Annemarie Mol. Then, I foreground epistemological currents that connect the *problem of the body* to the concept of death denial in contemporary Western society.

Dignity

The concept of human dignity is central to sustaining moral discourse in ethics, bioethics, and end-of-life care (Pullman 2004). However, ambiguity around the concept of dignity draws criticism from scholars across various disciplines (Pullman 2004). They are rightfully concerned that nebulous and conflicting definitions of dignity lack the necessary precision to guide decision-making in health-care policy development (Pullman 2004). Drawing on the definitions proposed by Rodríguez-Prat et al. (2016), I will attempt to dispel some obscurity around dignity. Among the myriad of pathways that one can ponder dignity, I choose 2 divergent concepts discussed by these authors because they encapsulate inherent and contextual factors that influence one’s perception of dignity. *Basic dignity* refers to “intrinsic and ontological” aspects of humanity that are fundamentally lasting and absolute (Rodríguez-Prat et al. 2016; Pullman 2004, 174). In contrast, *dynamic or personal dignity* encompasses subjective perspectives of the experiences and the context in which they occur (Rodríguez-Prat et al. 2016). To consider dignity at the end of life in the context of incarceration and grounded in palliative care, I leverage the moral significance of inherent human dignity to promote personal dignity behind bars.

In health-care practice, the meaning of dignity becomes illuminated through the contextual elements of relational engagement, policies, places, and technologies (Pols et al. 2018). From the patients' perspective, dignity is often understood through the mediating elements of autonomy and control (Rodríguez-Prat et al. 2016). When considering these elements in relation to each other, the study by Rodríguez-Prat et al. (2016) delineated 3 themes: dignity as the loss of bodily function, dignity as social identity, and dignity as autonomy in decision-making. Similarly, theories of well-being offer discussions on what constitutes a "good death," the concept closely related to *dignity in dying*. (Campbell 2020, 607). Campbell (2020, 609) identified 4 aspects contributing to the perception of a good death: "the place of death, one's company in death, the cause of death and one's manner of facing death." Reflecting on these aspects, the tension between a good death and prison constraints is palpable. For example, the architectural design of prisons is unsuitable to accommodate the disability and frailty associated with aging (Turner et al. 2018). Simple accommodations available to the public in the community settings, such as pressure mattresses, accessible showers, and mobility aids, are rarely available and often impossible inside prisons due to the size of cells and prison beds (Turner et al. 2018). Restricted by spatial limitations and organizational policies, protecting dignity during end of life can be very challenging within the bounds of incarceration.

The definition of dignity becomes secondary to "the crafting of dignity in a situation that cannot be influenced, or when opposing values clash" (Pols et al. 2018, 90). So, even if society agrees with the notion of *basic* dignity for prisoners, how can *dynamic* dignity be enacted in the carceral context? To answer this question, a consideration of the following quote at length is useful:

What any society tolerates or permits with regard to the expression of individual liberty (personal dignity) will be constrained by this basic notion (basic dignity), even as that society's understanding of basic dignity is, to some extent, shaped and altered by the various expressions of personal dignity, which are permitted or tolerated over time. (Pullman 2004, 176)

In other words, *basic* and *personal* dignity are socially embedded, created, and maintained through complex inter-relational dynamics. Taking a point of departure from *basic* human dignity, preserving the *personal* dignity of prisoners during end of life through timely access to quality palliative care becomes an issue of equity if the standards of such care diverge from those in the general population. Critical analysis of multiple socioeconomic and political realities that underpin health inequities outside the correctional institutions can shed light on how these inequities might be mitigated inside them, beginning with sustaining dignity during end of life.

Body

Dignity as a principle is an abstract concept and becomes tangible only in connection to embodied human beings. But how human beings are viewed in contemporary society is telling. From Plato, who believed that "man is a dual creature," to Descartes, who was convinced of "a sharp division between spirit and matter," mainstream Western philosophical traditions embrace the duality of human nature (Gaarder 1996, 88; 233). This duality draws a sharp division between the mind and the body and between humans and the environment (Mol 2021). Such a view of humans is problematic in the way it assigns superiority to the mind over the body and to humans over nonliving things. Drawing on Mol's (2021) ideas, I propose a more grounded and realistic representation of human

bodies where physical aspects of breathing, eating, smelling, tasting, nurturing, and satisfying bodily needs form a new ontological perspective on what it is to be human. Moreover, in turn, this transformed appreciation for physical aspects of human bodies, symbiotic with their surroundings, can disrupt the comfortable avoidance of the needs of incarcerated people as they experience end of life in prison.

In her book *Eating in Theory*, Mol (2021) uses the term "intellectual apparatus" and problematizes the split of "a lowly, mortal body, and an elevated, thinking mind" (p. 3). Mol's counterposition is clear:

What, if I wonder, we were to interfere with that hierarchy? What if we were to take bodily sustenance to be something worthy, something that does not just serve practical purposes, but has theoretical salience as well? (Mol 2021, p.1)

This line of thought has significant implications for how the bodies of incarcerated individuals are cared for during end of life. It is helpful to separate the connections I am making into 3 themes: the body as inferior to the mind, the body as an object of punishment, and the body as separate from the environment. Mol (2021) elucidates how cognitive processes that convey prestige and value are ranked higher than bodily functions such as eating and breathing and how the pursuit of liberty and truth is respected above labor and experience (Mol 2021). The supremacy of empirical methodology in research and societal hierarchal attitudes toward the senses of smell and taste present compelling evidence for this argument (Mol 2021). Such dominion of reason and logic over the human body is also evident in carceral systems (Garland 2011). Legal, judicial, and social discourses around discipline moved away from the punishment of the body to the "deprivation of liberty" (Garland 2011, p.768). A deliberate narrative is constructed around custodial punishment where the "suspension of rights" and freedoms become the target of a penalty with the goal of concealing the *body* (Garland 2011; Foucault 1977, 11). Modern society lacks the medieval proclivity for public displays of brutality, which led to a shift in discipline practices (Garland 2011). Foucault (1977) places this historical shift between the 18th and 19th centuries when the views on crime changed with the beginning of the Industrial Revolution. Two currents can broadly account for this shift. First, humanitarian activists criticized the spectacles of execution and the inhumane practice of torture (Foucault 1977). Second, a more sinister intent led to the development of modern prisons as societal structures of power sought to deter individuals from committing crimes and foster submissiveness (Foucault 1977). The latter represents the sinister element of punishment where discipline and control of prisoners began encompassing both body and mind (Foucault 1977). While this is a brief sketch of complex societal norms and policies that led to the birth of prisons, my goal is to underscore and denounce the current ethos of aversion to bodily pain and suffering. Such aversions are not innocent and inconsequential but have resounding implications for prisoners, especially those with terminal illnesses. Incarcerated individuals remain embodied even after their freedoms and rights are stripped away, and their bodies experience "containment and deprivation" (Garland 2011, 768).

Ambitions of early Western philosophers who sought to detach from the body and its environment and seek enlightenment in the reasoning of their minds influenced societal attitudes toward the human body. The disconnect between abstract thought and practical reality is especially palpable in correctional settings where the bodies of prisoners become collateral objects of legal punishment

(Garland 2011). Both prisoners' bodies and the carceral environment are hidden from the public view by the clever rhetoric of "suspended rights" (Foucault 1977, 11). However, the suspension of rights has a physical dimension, and incarcerated bodies are not floating in imaginary space but are forcibly tethered to the prisons' landscape (Garland 2011). The literature identifies the elements of carceral institutions, such as sexual violence and deprivation, physical abuse, malnourishment, overpopulation, and inescapable noxious odors (Garland 2011). As Crane and Pascoe (2021) eloquently expressed: "living conditions can become chronic health conditions, especially in prisons" (p. 308). In other words, health inequities are exacerbated by social inequities through the apparatus of institutionalization (Crane and Pascoe 2021).

Systematic concealment of incarcerated bodies and the environment they inhabit effectively discourages public oversight and silences the critique of practices that call to question equitable access to palliative care. A significant philosophical and practical shift in how bodies are viewed and valued is overdue in current societal discourses.

Death denial

In addition to problematizing the *body* as conceived in the carceral system, I foreground how the concept of death denial feeds into *the problem of the body*, permeates multiple spheres of social life, and contributes to inequities during end-of-life experiences in prisons.

An otherwise impermeable prison environment becomes infused with death denial as societal belief and values are played out inside prisons' culture through the dynamic interaction of its actors. Moreover, death remains a taboo in contemporary Western societies (Robert and Tradii 2019). Early European anthropologists and sociologists observed human's struggle to accept the natural phenomenon of death (Robert and Tradii 2019). In *Reflections on War and Death* (1918), Freud pondered that while everyone understands death is inevitable, how people behave contradicts this understanding (Robert and Tradii 2019). Sociological literature suggests that certain philosophical and religious values appear as defence mechanisms to cope with "the incomprehensible reality of death" (Robert and Tradii 2019, 250). In the late 1950s, British anthropologist Geoffrey Gorer in the article *The Pornography of Death* (Gorer 1955) provocatively remarked that sex replaced death in the taboo realm, with the latter receding from the public discourse (Robert and Tradii 2019). Later, the same author conducted surveys to explore adults' relationships with death and noted "the dissolution of mourning" rituals, with the increasing numbers of people dying unaware of their terminal diagnoses (Robert and Tradii 2019, 251).

Western traditions around death and dying are prolific in their attempt to disconnect and conceal death (Robert and Tradii 2019). For example, the care for the deceased bodies is often transferred to funeral parlors, and frank conversations about death are replaced with hushed euphemisms, especially around children (Robert and Tradii 2019). Such pervasive, culturally constructed fear of death and dying can hinder the care provided at the end of life. If caring for diseased loved ones is fraught with conflict and anxiety, then facing the sufferings and often the undignified death of incarcerated individuals is intolerable. As Roulston et al. (2021, 224) summarized Granse (2003), "offenders are a forgotten class, often receiving societal or professional inattention, indifference, and hostility."

Shrouded in obscurity and warehoused from public view, the incarcerated population profoundly experiences death denial.

Evading mortality is dangerous as it can hinder early assessments and diagnostics, access to pain management, care planning, and ultimately, equity-informed palliative care. If penal systems deliberately conceal bodies and view them as collateral to the deprivation of liberty, then any notion of death is erased. Prisoners' lives and deaths rendered invisible become "the embodiment of inequality" (Crane and Pascoe 2021, 319).

Social dimension

The ripple effect

Beyond impacting the individuals who experience end of life in prison, death in carceral setting profoundly affects those in close proximity and the family and friends beyond prison walls (Roulston et al. 2021). Prison staff and bereaved families are at risk of complicated and prolonged grief disorders, which can lead to social isolation, poor physical and mental health, and substance abuse (Roulston et al. 2021). A scoping review of the experiences of prison staff and bereaved relatives identified many adverse physical and psychological outcomes for those who provide direct and indirect care to prisoners during end of life (Roulston et al. 2021). Staff reported feeling unprepared to support the dying prisoners adequately and manage their emotional needs in the aftermath, especially when the closed-door debriefing strategies isolate them from their peers (Roulston et al. 2021). Faced with the realities of the carceral environment, the bereaved families reported long-term emotional effects from observing the undignified treatment of the dying relatives (Roulston et al. 2021). For example, prisoners are seldom uncuffed and unguarded in their final hours (Roulston et al. 2021). In that sense, marginalization and health inequities extend to families, staff, and other prisoners who live through the experience of death in a correctional setting (Roulston et al. 2021). These examples provide irrefutable evidence that dying in prison constitutes a social justice issue with profound reverberating individual, social, and transgenerational effects.

Places of death

Finally, I situate death in prison within its spatial boundary and consider how lived experiences of prisoners in these spaces relate to the concept of equity. I would like to begin the conversation with questions posed by Knox (2021):

Do places have the power to mediate our experiences of and attitudes toward dying? Since we have limited authority over how and what kills us, do we then root our control of, dignity in, and reconciliation with death based on where we die? (p.1)

While these questions overestimate the freedom of choice and the extent of human agency around the place of death, they nevertheless underscore the significance of build environment in the dying experience. Physical elements of spaces carry a compounded psychological meaning that is often socially and culturally constructed (Knox 2021). Spaces become *places* as they are assigned individual meanings by invoking personal histories and memories (Relph, 1976, as cited in Knox 2021). At the end of life, places become inhibited with time, where its passage is acutely palpable (Knox 2021). People often devote this time to reflecting, re-evaluating life stories, and confronting the universe (Knox 2021). Imagining carceral environments entrenched with omnipresent authority and surveillance, it is difficult to envision them as spaces of solace, ritual, and reconciliation of one's mortality.

The space syntax theory postulates how building designs and layouts imply social strata and the hierarchies of relationships within them (Knox 2021). This theory, developed by Bill Hillier and Julienne Hanson, examines social connotations embedded in architectural designs (Knox 2021). In other words, “buildings acquire meaning and identity” that guide the expression of acceptable tangible behaviors and foster intangible social practices (Knox 2021, 2). Jeremy Bentham’s panopticon, a prison design that allows for continuous surveillance of all prisoners from the central vantage point, exemplifies how designed spaces play more than a nominal role in shaping the relationships of power and control (Knox 2021). Some contemporary architecture that mimics the panopticon includes schools, hospitals, malls, and governmental institutions where encounters take a predetermined form and where larger “socially sanctioned” inequities find embodiment (Knox 2021, 2).

Where people die and what social, political, economic, and cultural implications it has were explored in North American literature to some extent with the key aim of improving care (Brown and Colton 2001). However, investigations of this phenomenon through a social science lens are scarce (Brown and Colton 2001). Coming a full circle, the ideal locale for dying shifted from hospital to home (Brown and Colton 2001). However, current palliative care policies take their cue from the middle class by emphasizing home and hospice death, erroneously assuming everyone has access to stable housing and other social and fiscal resources to achieve such an ideal (Robinson and Gott 2020). For incarcerated individuals, such a trend is concerning. More explicitly, compounded effects of incarceration with associated physical, mental, and social deprivations expose prisoners’ vulnerabilities during the end-of-life transitions in achieving dignity, managing sufferings, and coming to terms with mortality. When home death is hailed as an optimal goal, the development and financing of community alternatives and in-prison hospices become inconsequential. It is important to highlight that the idea of in-prison hospices is fraught with tension and critique as some scholars argue they normalize death in prison (Hudson et al. 2019). However, lack of responsive, compassionate release policies, lack of community infrastructure, and severed family ties means that many prisoners will experience loss of dignity at the end of life either by contending with existential suffering from dying while incarcerated or being barred from quality palliative care.

Nevertheless, the hidden assumptions of current palliative care policies that proliferate the “home is best” narrative can illuminate the issue of dying in prison. For example, prolonged social exclusion from the outside world and embodiment of institutionalized behaviors often leads to disrupted familial relations, social anxieties and an inability “to transition to life beyond prison” (Crane and Pascoe 2021, 313). So, whether the prisoner is released on compassionate grounds due to terminal illness or due to the completion of his sentence, death at home becomes an unachievable ideal as fiscal and social resources are severed. In that sense, “home is best” rhetoric contrasts against the realities of vulnerable groups to reveal how prison death is inequitable. Perhaps, considering structural inequities as experienced by individual prisoners instead of places of death as demarcated by prison walls offers a better understanding of the connections between one’s social gradient and a site of death. I hope such a perspective can inspire solutions where access to quality palliative care, dignity, and solace at the end of life can be achieved for people who experience incarceration.

Conclusion

I remain skeptical about Giddens (1984) statement that “to be a human being is to be a purposive agent” (p. 3). Current political and institutional policies reproduce social conditions that perpetuate health inequalities against vulnerable populations across Canada, effectively limiting their agency. The concept of doubly vulnerable exemplifies compounded challenges faced by individuals whose palliative care needs converge with profound social disparities (Reimer-Kirkham et al. 2016). Incarcerated individuals, in particular, experience a constellation of individual burdens and collective barriers that hinder their access to quality palliative care and highlights how dying in prison is equitable. This discussion aimed to explore the epistemological foundations of death in prison through philosophical, social, and spatial lenses. The examination of dignity, the human body, and death denial was undertaken to foster new perspectives. Scrutinizing carceral experiences of death and dying as morally underpinned, socially constructed, and spatially located propels them into a social justice realm and begs for a reorientation of equity in line with a moral compass. Due to the paucity of research into carceral experiences of death, I hope these reflections disturb public perceptions of the prison environment and illuminate hidden spaces where incarcerated bodies encounter bodily pain and suffering.

Competing interests. None.

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