Examining Carceral Medicine through Critical Phenomenology

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Abstract: The general aim of this paper is to provide insight into the relevance of critical phenomenology for the study of the patient-provider relationship in health care systems in U.S. jails, prisons, and detention facilities. In particular, I utilize tools from the work of scholars studying phenomenological approaches to health care and structural forms of oppression to analyze several harms that arise from the provision of medical care under the punitive constraints of carceral facilities.

Keywords: correctional health care, critical phenomenology, critical prison studies, Frantz Fanon, prison medicine

1. Introduction

In "Medicine and Colonialism," Frantz Fanon (1965) critically implicates several impasses that arise from the provision of medicine under contexts of colonialism. His essay offers a critical appraisal of medical care in Algeria from the perspective of a health care provider who is himself also subject to racist hierarchies of difference under French colonial rule. Drawing from his experiences as a clinician, Fanon argues that developing trusting relationships of care between patients and providers often becomes nearly impossible under conditions of colonial violence. Reflecting on such claims, some contemporary readers of Fanon in the Global North may consider themselves removed from the kinds of colonial violence and anticolonial struggle that his work so carefully describes. However, this paper seeks to bring Fanon's insights and those of other theorists of structural oppression into a more proximate conversation with facets of contemporary health care systems in the Global North. In this vein, I argue that tools from critical phenomenology can be used to examine the harms of U.S. correctional health care—that is, health care services in prisons, jails, and detention facilities—wherein patterns of structural violence bear significant effects on incarcerated patients. Toward this end, I demonstrate that specifically phenomenological harms of incarceration entail that many

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medical providers are not sufficiently able to carry out their duties to provide caring, therapeutic, or ameliorative encounters with their patients while operating under the punitive aims of jails, prisons, and detention facilities. Instead, as Fanon's work and that of other critical phenomenologists demonstrate, the conditions of correctional medicine often situate patients and providers in oppositional relations that entail perpetual forms of conflict. Such seemingly intractable tensions between patients and providers, I propose, emerge from the conflicting goals of health care and those of punitive institutions.

To defend these claims, I first offer an introduction to the provision of health care in U.S. prisons and jails, including a brief historical discussion of the emergence of the field of correctional health care and the common health care needs of incarcerated populations. Second, I introduce an article by Jennifer Poteet (2001)[1] in which the author describes a clinical encounter with a gynecologist at Danbury Federal Correctional Institution, a federal prison in eastern Connecticut. Poteet's piece outlines several problems that arise within correctional health care settings, and her description helps clarify the complex nature of what I describe in the following section as the phenomenological harms of medical care in punitive contexts. Such forms of harm stem from intersubjective aspects of confinement and cycles of structural violence that characterize, yet often exceed, the institutional settings of correctional facilities. To clarify these claims, I turn in the third section to resources from critical phenomenology to frame these specific harms and to elaborate upon several embodied and experiential considerations that surface in clinical medicine under conditions of structural violence. In the concluding section, I return to Poteet's account, and utilize the resources I have outlined from critical phenomenology to shed light on some of the structural barriers to medical care within carceral settings.[2]

2. The situation of U.S. correctional health care

The emergence of a consolidated field of clinical practice, scholarship, and legal discourse concerning health care in carceral facilities in the United States is relatively recent. Prior to the 1960s, U.S. courts upheld what B. Jaye Anno (2001) and other prison studies scholars call a "hands-off" doctrine (15). This era was marked by a general noninterventionist stance regarding the claims for legal redress made by incarcerated peoples and a general lack of judicial oversight into the specific practices of U.S. penal institutions (15). The 1960s and 1970s mark a somewhat significant shift in U.S. carceral history wherein the provision of medical care, along with issues such as prison overcrowding, labor laws, and access to legal representation became part of a broader public discussion regarding "prisoner's rights." However, this "prisoner's rights movement," as it has been labeled, was not only a legal movement. As Robert T. Chase (2015) demonstrates, many incarcerated peoples began using a two-pronged strategy of "mass protest tactics alongside civil rights cases and class action lawsuits to demand public visibility" (75). Prison uprisings across the

country throughout the 1970s and 1980s and the burgeoning prison abolitionist movement led by African American political prisoners were part of the development of this public discourse as well (75–76).

With respect to health care in prisons and jails in particular, U.S. courts throughout the 1960s demanded that claimants demonstrate extreme deprivation to be granted any form of redress in prisons and jails. Their claims were required, in effect, to "shock the conscience of the court" to rise to the level of a constitutional violation (Anno 2001, 15; citing *Church v. Hegstrom* 1969). In this sense, the courts generally deferred to individual carceral institutions to "do the right thing," and, as Anno notes, "the courts deferred to the opinion of correctional physicians and officials that reasonable care was being provided" (16).

Yet, by the early 1970s, increased public pressure to address prison and jail conditions and the heightened litigation and political efforts of prisoners began to give rise to an identifiable field of correctional health care. The first national surveys regarding the availability of health care in prisons were conducted in the 1970s when the American Medical Association (AMA) began to take a pointed interest in medical care in carceral facilities (Anno 2001, 12). From these early surveys, the inadequacy of health care in correctional facilities began to surface through the consolidation of a body of empirical literature. For example, two-thirds of the 1,159 jails analyzed in this early research by the AMA reported that the only "medical facility" for many jails was first aid. In addition, 16.7 percent reported that their jails lacked even first aid resources (12).

In the mid-1970s, the American Public Health Association and the AMA each offered a set of comprehensive guidelines directed at the provision of health care in carceral facilities. The interventions of professional health care organizations in the 1970s began to provide specific guidelines regarding the forms of training, intake procedures, types of equipment, preventive care, mental health services, dental and optometric services, and other detailed standards by which correctional staff, administration, and health care providers were legally expected to abide (Anno 2001, 24). In addition, the 1976 Supreme Court decision in *Estelle v. Gamble* declared that incarcerated persons were entitled to: "1. access to care for diagnosis and treatment; 2. a professional medical judgment; and 3. administration of the treatment prescribed by the physician" (Greifinger 2007, 2). *Estelle v. Gamble,* thereby, served as the legal mandate that incarcerated persons could not be denied health care while in custody, and in 1979 this mandate was extended to include pretrial detainees and juveniles in detention as well (2).[3]

Responding, in part, to these public discourses, the AMA established a program in 1984 that would eventually become the National Commission on Correctional Health Care. Today, this commission has 501(c) (3) nonprofit status, two regular periodicals (a magazine and a peer-reviewed journal), an

accredited health services program, and several other educational, legal, and administrative resources dedicated to the provision of health care in U.S. correctional facilities. Since the 1980s, correctional health care has become a multibillion-dollar industry in the United States. For example, a recent report notes that the United States spent $8.2 billion on prison health care in 2009 (Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation 2014).[4]

Shifting the focus to contemporary health care needs in prisons and jails, some of the most pressing health care needs affecting incarcerated populations, according to a recent report from the Vera Institute of Justice, are: mental illness, with about 14.5 percent of people incarcerated in men's jail facilities and 30 percent of people incarcerated in women's jail facilities having some form of serious mental health needs, including treatment of schizophrenia, depression, and bipolar disorder; substance use and addiction; infectious diseases such as HIV/AIDS, hepatitis C, tuberculosis, and sexually transmitted diseases; chronic diseases such as asthma, hypertension, and diabetes; suicide and self-harming behaviors, including one-third of deaths in jails from 2000 to 2009 resulting from suicide; reproductive health care needs, including prenatal and postpartum care; and geriatric health care needs, including treatment of mild cognitive impairment, Alzheimer's disease, and dementia (Cloud 2014, 5–12). Often, incarcerated persons with these health care needs are met with insufficient staffing and medical resources in carceral facilities (Anno 2001, 50) that have both immediate and long-term consequences. Moreover, despite the consolidation and expansion of correctional health care services since the 1970s, only 17 percent of correctional facilities across the nation have been accredited by the National Commission on Correctional Health Care (Cloud 2014, 14). This means that even with increased public attention and the institutionalization of medical care in U.S. prisons, jails, and detention facilities, several ongoing forms of neglect, undertreatment, abuse, and, as I argue below, phenomenological harms continue to exist in correctional health care settings.

Alongside these concerns regarding the provision of health care within correctional facilities, communities of color and poor communities across the United States—the communities most negatively impacted by the massive upward trends in rates of incarceration since the 1970s—suffer vast health disparities as well. Namely, these communities disproportionately suffer disparities in health, health outcomes, and morbidity when compared to white and middle- to upper-class communities (Artiga et. al. 2015; Kawachi et al. 2005; Smedley et. al. 2003). Thus, while mass incarceration disproportionately targets and impacts communities of color and poor communities, these same populations are additionally suffering the racial, ethnic, and socioeconomic barriers that impact health care and health outcomes in the United States more generally. In this vein, mass incarceration itself has been empirically linked to poor health outcomes and, as such, has become a pronounced interest

among researchers and advocates working in the field of public health as well (Cloud 2014, 15–19).

3. A clinical encounter in correctional health care

Incidents of undertreatment, overtreatment, and neglect in correctional health care are numerous, and can be traced across various legal and empirical sources. My aim in this section, however, is to highlight a first-person description of a medical encounter offered by Jennifer Poteet (2001) (which is reproduced as written without correction to punctuation), a woman incarcerated at Danbury Correctional Institution in Connecticut. The details of Poteet's account, I propose, help outline a complex set of phenomenological harms that she encounters as an incarcerated patient during a clinical encounter. As I discuss in the following sections, her description reveals both the importance of first-person accounts provided by incarcerated patients, and the relevance of critical phenomenology in analyzing underlying structures of harm in correctional medicine.

In "Gyn and Bitters," an article published in *POZ Magazine* in 2001, Poteet describes her encounter with a gynecologist at Danbury Federal Correctional Institution (hereafter referred to as "Danbury"). Danbury, a prison that opened in 1940, has garnered public interest for several reasons. For instance, the prison gained attention in the 1970s because of a fire in which five incarcerated men were killed and seventy-one others were injured when they were trapped inside a burning unit (Henry 1977).[5] Also of note, Danbury has held several political prisoners, including radical activists of the Puerto Rican independence and Black Power movements, including Silvia Baraldini, Susan Rosenberg, and Alejandrina Torres (McIntire 1997). Rosenberg (2011), for example, writes extensively about the conditions of her incarceration and about the significant HIV/AIDS related activism among incarcerated women at Danbury in her autobiography, *An American Radical: Political Prisoner in my Own Country*.

Poteet's description of her medical encounter at Danbury raises a crucial set of phenomenologically relevant factors involved in the provision of health care in correctional facilities. Namely, as I discuss below, Poteet provides a description of intersubjective forms of harm that arise from medical encounters in correctional institutions.

Poteet begins "Gyn and Bitters" by describing her need to visit the prison gynecologist at Danbury and writes that she feels "lucky to have HIV at a time when it is finally recognized that HIV can officially cause gyn problems." She also notes that people incarcerated at Danbury are allotted a Pap smear every six months according to the prison's medical standards. Prior to her meeting with the gynecologist, she learned that she needed a loop electrosurgical excision procedure ("LEEP" procedure) to remove precancerous cells in her cervix. She had already researched the procedure and came prepared to the clinical visit with, in her words, "a different problem." Poteet writes:

> I take a deep breath and launch into it: I have special needs. Not so much because I have HIV, but because of the sexual abuse I've suffered—from a childhood of emotional abuse to hitting the streets at 13 and learning the hard way that most of the people willing to help me were predators who got off seeing me in pain, Those experiences have made it impossible for me to lie calmly on my back on a table, naked, with my legs spread open. Shame, powerlessness and fear overtake me; my body hears only those emotions, no rational thoughts can get through, the first two times I went for Pap exams, I had anxiety attacks in the waiting room. On my third try my shrink was allowed to hold my hand and talk me through the exam. So I tell the doc that I'll need to be put asleep through the exam.

The physician's response, Poteet writes, is laughter. She then insists to the physician that "you won't be able to do the procedure if I'm not sedated." His response is, in her words, a "giggle." He then asks her, "Just what happened to traumatize you so badly?" Poteet then states that she is immediately made aware, given his response, that the physician does not want, in her words, "to sympathize." Rather, she writes, "he wants to make me back down, so he will have less work to do. Anything out of the ordinary routine of shackles, surgery, strip-search and back to the joint means more work for him." She attempts to explain the nature and extent of her trauma to him, stating that "It's accumulation of events over a long time." His response is more laughter. At this point, she writes: "Now I know for sure that my doctor is my enemy, and I hate him. His only concern is talking me out of anesthesia."

Poteet recounts that the physician tries to divert the conversation regarding her request for anesthesia by appealing to a set of bureaucratic constraints. He makes comments such as "this makes things difficult" and "this will involve paperwork and extra security arrangements. It may mean we can't do the surgery soon." Poteet addresses the reader and asks, "This is my doctor? I'm quite sure he's not supposed to pressure me to ignore my physical and mental needs by suggesting he'll withhold surgery." Again, addressing the reader, she notes, "To the system I am merely an inconvenience. This doctor has probably been following prison policies for so long that to expect him to respond to my concerns is laughable. Hating him is a waste of my time." Poteet's response to this encounter is to request that her psychiatrist make a recommendation to her gynecologist about her need for sedation. Describing her interaction with her psychiatrist, Poteet writes: "I see my shrink, and she doesn't laugh, She hears cases like mine all the time and knows that abuse messes you up in invisible ways. So she agrees that I must be sedated for the procedure, and her word carries weight." Concluding the piece, Poteet writes: "Yeah, I'm lucky this time. But I'm scared about the next, and I'm frightened for other women in here. Botched surgery can give you an ugly scar—a lifetime reminder of how little you are valued. So far, my scars, don't show up on the outside."

Poteet's description of her encounter with a gynecologist at Danbury demonstrates several important phenomenological features of health care under

conditions of incarceration. More specifically, as I discuss in the sections below, Poteet's description provides crucial insight into harms that arise in correctional health care through augmentations of *temporality* and *relationality* (defined and discussed in more detail below) in the clinical encounter. That is, her description points to severe problems that involve the expectations for timely access to health care and for supportive patient-provider relationships in carceral settings. Poteet's description, then, can be interpreted through the lens of critical phenomenology, a philosophical approach that, among other things elaborated below, attends carefully to themes of temporality and relationality. In the following section, I offer a brief overview of insights from critical phenomenology before returning, in the final section, to the account offered by Poteet.

4. Framing correctional health care through critical phenomenology

To outline the specific analytic tools in critical phenomenology to address some of the harms in correctional health care, it will be important to preface my analysis of Poteet's medical encounter with a brief overview of some of the relevant literature in the field. In *Solitary Confinement: Social Death and Its Afterlives,* Lisa Guenther (2013) defines critical phenomenology as "a method that is rooted in first-person accounts of experience but also critical of classical phenomenology's claim that the first-person singular is absolutely prior to intersubjectivity and to the complex textures of social life" (xiii). Guenther's research on solitary confinement and the experiential harms of this form of punishment develop out of her readings of figures that she includes within the discourse of critical phenomenology, such as Fanon, Maurice Merleau-Ponty, and Emmanuel Levinas. One characteristic feature that unifies the views of these authors, she argues, is that they each develop conceptions of embodied intersubjectivity that rely on the immensely complex social worlds that we inhabit. Distinct from this approach, classical phenomenologists such as Edmund Husserl and Martin Heidegger attempt to "bracket" or separate methodologically the particularities of experience related to personal and social identity from ontological questions of being. Their purpose for this was to understand better, in Guenther's words, "the transcendental condition of absolutely singular and nonworldly first-person consciousness" (xiii). However, critical approaches to phenomenology have attempted instead to understand the richly embodied experiences of the conditions of human being without analytically setting aside complex features of our social worlds.

In addition, "embodiment," in the sense employed in critical phenomenology, often refers to the lived body as it is experienced first-personally. This perspective is often contrasted with (sometimes tacit) conceptions of embodiment that consider the body as an object from a third-person perspective. This distinction between the lived body as it is experienced and the body viewed objectively has deep roots in classical phenomenology as well, and has provided

a rich basis from which theorists like Husserl and Merleau-Ponty have analyzed complex philosophical themes such as perception, consciousness, intentionality, language, and time.[6]

Critical phenomenological approaches to race and gender have also become well developed throughout the twentieth and twenty-first centuries. While classic works in this discourse such as Simone de Beauvoir's *The Second Sex* ([1949] 2011) and Frantz Fanon's *Black Skin, White Masks* ([1952] 2008) offer nuanced approaches to understanding the lived conditions of racial and gendered experience, research in the last several decades has expanded phenomenological investigations on these topics extensively as well. For example, Iris Marion Young (2005) offers a pivotal approach in feminist theory regarding the forms of motility, spatiality, and embodied inhibition that are the conditions of lived experiences of people with feminine bodily comportment. In addition, theorists of race and gender, such as Linda Martín Alcoff (2006), Alia Al-Saji (2009), Emily Lee (2014), Mariana Ortega (2016), Gayle Salamon (2010), Gail Weiss (2015), and George Yancy (2008) have each examined the varied nature of racialized and gendered embodied experience through phenomenological lenses. Lastly, phenomenological approaches to medicine and disability have also developed extensively over the last several decades. In this vein, works from theorists such as S. Kay Toombs (1987, 1988, 1995), Havi Carel (2008, 2011, 2012), Gayle Salamon (2012), and Fredrik Svenaeus (2000a, 2000b, 2000c) have brought key insights to structures of perceptual, temporal, and hermeneutic aspects of embodied being to shape discourses on health, bodily function, and first-person experiences of motility, pain, and illness.

One significant overlapping theme among many of these diverse works is that normative and social conditions of human existence are themselves constitutive of human experience rather than additive or separable from it. There are, thus, important ways in which critical phenomenological approaches to gender, race, illness, and disability can offer theoretically rich tools to understand phenomena such as medicalized embodiment under conditions of incarceration, including, for example, the constraints of confinement, criminalization, and structural oppression detailed in Poteet's article.

One particularly rich body of philosophical research on the phenomenological relationship between forms of structural oppression and medicine can be found in the writings of Fanon. Fanon, a black Martinican clinical psychiatrist who practiced medicine in France, Algeria, and Tunisia, focuses in his writings on the dynamics of colonial medicine. His analyses, for example, poignantly connect various themes regarding trust/mistrust and structural oppression operating in the clinical setting. More generally, there are several problems related to trust and miscommunication between patients and clinicians that impact the health disparities that arise in clinical medicine, including racial and ethnic disparities (Murray and McCrone 2015; Cooper et al. 2003).

While much of the empirical research on these issues spans the last several decades, Fanon's writings offer an early example of a phenomenological approach to clinical medicine that addresses how trust and communication impact the forms of relationality available between providers and patients under structural forms of oppression. Fanon's emphasis on the embodied iterations of trust/mistrust, thereby, highlights what I describe as the relational harms that arise in correctional medicine.

The term "relationality," in the sense I am using it here, refers to the set of meaningful constitutive associations that living beings have to one another and to the objects in their worlds. Such an account follows Guenther's (2013) interpretation of the term in *Solitary Confinement*. She states that "a living being, from the amoeba to the poetic genius, articulates both a relation to itself and a relation to something other than itself, something that sustains and supports its own life. In other words, life implies a certain bearing in relation to the other, a comportment toward a world shared with others" (121). Such a sense of relationality also entails a set of meaningful expectations or possibilities that makes the world navigable or habitable. Accordingly, our relationships with other people, including, for example, interactions with institutionally situated others such as caregivers or law enforcement officers, are constituted by those expectations and intentional relations within our worlds of sense. I, thus, describe the relational harms of correctional health care as the ambiguous offering of a set of therapeutic possibilities under the constraints of the punitive demands of the carceral system. As such, both life and death become mutually entwined in medical settings in prisons, jails, and detention facilities.

To clarify, in Fanon's 1959 work *L'an cinq de la révolution algérienne* [literally, "Year Five of the Algerian Revolution," translated in English under the title *A Dying Colonialism*], the author examines a form of miscommunication and mistrust between French clinicians and Algerian patients in medical institutions in colonial Algiers. He states that French medical providers expect the bodies of colonized Algerian patients to be "more talkative" ("*plus bavard*") than the patients' own descriptions of their embodied conditions (118). This phrase appears in the context of a discussion about the manner in which clinical examinations proceed when performed by French doctors who have lost all trust with their patients. Fanon explains that under such scenarios, clinicians interpret the intentions of their patients as contrary to the aims of health and the therapeutic efforts of the medical institution. Instead, Algerian patients, due to Algerian liberation efforts that mark a rejection of French colonial domination, are believed to harbor ill intentions toward their physicians and "Western" medical institutions more generally. French clinicians, thus, discredit a priori anything they might say about their bodies or themselves and expect that the patient's body will be the only "objective" measure whereby the patient's malady can be understood. In this vein, the verbal symptoms expressed by the patient become secondary to the clinician's examination of

the body. Through this expectation, patients' experiences of illness are deemed largely inconsequential, and the lived experiences of the patient's body are largely dismissed in the process of forming a proper diagnosis, to the extent that this is possible absent any input by the person whose body is under consideration. The clinician assumes instead that the body is able to "speak for itself" in a manner that will not be obscured by the colonial situation.[7]

Drew Leder (2016) recently examined a similar phenomenon in *The Distressed Body: Rethinking Illness, Imprisonment, and Healing*. He describes an "objectifying touch" as a clinician's discerning engagement with a patient's body whereby the clinician assumes a "corpse-like" body that offers the physical evidence necessary for proper diagnosis (43). In this sense, he writes, "the physical examination came to be viewed as providing more objective and therefore more reliable data than subjective patient accounts of symptoms" (43). Appearing to echo Fanon's remarks, Leder points to the clinical dismissal of patients' descriptions of their own embodied experiences. He also argues that, throughout the twentieth century, the objectifying touch becomes largely replaced with diagnostic technologies such as MRIs, X-rays, ultrasound images, CT scans, blood tests, and so on. These technologies, then, render diagnosis possible without requiring the clinician's touch, the "absent touch" (43) that, according to Leder, characterizes much of modern medicine generally. The consequence of this, he proposes, is that an intersubjective relationship is replaced by a subject-object relationship or an object-object relationship wherein the physician either interacts with an already-objectified body or a machinated series of diagnostic equipment interacts with the patient's already objectified body. As a result, Leder argues, the patient is further alienated from their body and denied a "healing" touch when it might be most desired during moments of distress, illness, and pain (45).[8] For Leder, this absence of touch is characteristic of modern medicine generally.

According to Fanon (1965) in his writings on colonial clinical encounters:

> We often hear it said that a certain doctor has a good bedside manner, that he puts his patients at ease. But it so happens that in the colonial situation the personal approach, the ability to be oneself, of establishing and maintaining a "contact," are not observable. The colonial situation standardizes *relations*, for it dichotomizes the colonial society in a marked way. (127; emphasis added)

Here, Fanon's comments regarding the dichotomous relationship between the colonizer and the colonized points toward a stark contrast between those patients who are subject to oppressive colonial dominance and control and those clinicians who are viewed as perpetrators of that colonial violence.

In this sense, the conditions for a trusting relationship between providers and patients are undermined in conditions of structural oppression. Referring to contexts of colonial violence, Fanon (1965) further states:

> In a non-colonial society, the attitude of a sick man in the presence of a medical practitioner is one of confidence. The patient trusts the doctor; he puts himself in his hands. He yields his body to him. He accepts the fact that pain may be awakened or exacerbated by the physician, for the patient realizes that the intensifying of suffering in the course of examination may pave the way to peace in his body. (123)

In this vein, Fanon articulates an amount of trust in the therapeutic relationship between providers and patients, or a confidence in the capacity for nonmaleficence in caregiving relationships. Unfortunately, however, this possibility for trust is undermined by conditions of structural violence. Namely, when medical science is "part of the oppressive system," every aspect of the clinical encounter, including the relations necessary to support the therapeutic process, is marked by it (121).

Regarding temporality, Guenther (2013) develops a sustained study of "prison time" in *Solitary Confinement*. She draws both on the punitive phrase "doing time" that surfaces in contexts of incarceration and the writings of Heidegger and Levinas on temporality and protention. She states that the "urgent demand to do nothing—to hurry up and wait—characterizes most aspects of prison life (196). The hyperregulation of schedules, the constant possibility of intrusion from guards and staff, administrative changes, and the "serving" of time due to the sentence of imprisonment augment the temporality and forms of futural possibilities that incarcerated people experience. In this vein as well, Leder (2016), in a section analyzing "lived time" during conditions of imprisonment, writes:

> Time itself has become something that must be served, an instrument of disempowerment. This is true not only on the macroscopic scale [i.e., the effects of sentences of imprisonment] but in the intricate management of daily time to which an inmate is subjected. When you sleep, hours in and out of the cell, limited opportunities for action are largely predetermined by prison authorities rather than natural inclination. (166-67)

According to Guenther (2013), the significance of these temporal augmentations is that the relation between past and future possibilities is not merely a cognitive or epistemic issue but an existential issue as well. That is, historical, perceptual, and intersubjective experiences are prefaced on the temporal "interplay of protention and retention" by which an embodied being-in-the-world anticipates and engages the world in a historically and socially meaningful sense (200–01).[9] In this sense, one finds oneself experientially located in a set of past and present interpretative and material possibilities that shapes and foregrounds one's futural existence.

In phenomenological accounts of illness and acquired disability, we find analytic attention to the experience of being subject to the normative and protentional expectations of medical institutions. For example, Havi Carel and

Rachel Cooper (2013) argue that a phenomenological approach to illness seeks to augment biologistic or behaviorist approaches to health and illness by providing a method of analysis that the other approaches lack. Namely, phenomenological approaches to illness focus extensively on the first-person experience of illness, disability, pain, and other significant modes of embodied understandings of disease. In this vein, Carel and Cooper's work highlights that phenomenological approaches can be used to examine the experiences of both health care providers and the experiences of persons who are ill, disabled, or otherwise in need of access to health care. Such an approach, Carel (2012) argues, can be a pivotal resource for training health care providers and for patients to utilize during their interactions with clinicians.

In several of Carel's articles and chapters on the relevance of phenomenology for clinical providers and patients, she outlines the need for health care practitioners to understand better the perceptual and physical experiences of their patients (e.g., 2014, 52; 2012, 98; 2011, 42). She argues that many providers develop a lack of empathy when dealing with their patients, a contributing factor for "much of the misunderstanding, miscommunication, and sense of alienation that patients report" (2014, 52). Carel's work poignantly argues that phenomenology is particularly apt to demonstrate "the transformation of the world of the ill person caused by the illness" (2014, 54). In this sense, she adds to the work of Toombs by highlighting themes that accompany the corporeal experience of illness. Following Toombs, Carel writes of characteristic features of illness that accompany experiences of illness (2012, 103). Among these, she includes Toombs's list of such characteristics as "the perception of loss of wholeness, loss of certainty and control, loss of freedom to act, and loss of the familiar world" and adds such characteristics of illness as "changes to the experience of space and time, lost abilities, and adaptability" (103). In this sense, both Carel and Toombs offer discussions of crucial facets of clinical medical encounters that attempt to bridge the differing orientations between experiences of illness and disability and experiences of caregiving, including the therapeutic relationship between caregivers and those who receive care.

To clarify further how these phenomenological approaches aid us in understanding the provision of health care in carceral settings, we can return to Guenther's (2013) work on solitary confinement. She writes that phenomenological traditions stemming from the work of Husserl and Heidegger appear to take the first-person singular perspective as a fundamental mode of analysis that must bracket out social and personal meanings. However, she notes a problem with respect to this method of "distancing" oneself: if our first-person reflective standpoint, including our orientations to our bodies and intentional capacities, are themselves constituted by intersubjective social layers of gender, race, class, ability, institutional space, and so on, then we cannot methodologically set these aside. In response to this concern, Guenther writes:

> Confronting these questions, and without claiming to have solved them, I have sought to develop a method of critical phenomenology that both continues the phenomenological tradition of taking first-person experience as the starting point for philosophical reflection and also resists the tendency of phenomenologists to privilege transcendental subjectivity over transcendental intersubjectivity.... For me, what is most valuable about the phenomenological tradition is the insight that there is no individual without relations, no subject without complications, and no life without resistance." (xv)

An important point here is that a sociopolitical conception of intersubjectivity is fundamental to critical phenomenological studies. This means that rather than bracketing social meanings, phenomenology must also describe the first-person experience of being subjected to socially constituted communities, identities, and meanings, including racialized, gendered, and institutionally constrained ways of being-in-the-world. In this vein, Guenther's interpretative work on and development of Fanon's oeuvre seeks to articulate the author's philosophical contributions to the study of phenomenology. Importantly, his analysis of, in her words, the "lived experience for the colonized subject, and its social and political meaning as containment, control, and exploitation—as well as resistance, solidarity, and the creation of new possibilities for collective life" become hallmarks of a critical phenomenological method for exploring the racialized conditions of oppression (42).

In addition, even Toombs's and Carel's invocation of a conception of "wholeness" that is lost through illness and acquired disability presupposes a social and historical set of possibilities whereby previously available integrations of self, world, and one's intentional efforts are afforded stability. However, as I argue below, the patterns of stigmatization, trauma, and criminalization that impact many of the lives of incarcerated people point toward the need for a conceptual shift away from previous iterations of "wholeness."[10]

Such methodological distinctions are important to raise in my efforts to address the harms endemic to correctional health care. A phenomenological approach to the subject, then, cannot bracket out the experiential conditions of racialized, gendered, and criminalized embodiment. Relatedly, we can also interrogate, alongside contemporary literature in social epistemology, for example, how even first-person experiential claims are normative, social, and value-laden (e.g., Medina 2012). If we treat first-person knowledge as intersubjective and relational, we are, thus, able to understand the pivotal claims made by incarcerated persons, including Poteet, that the harms of structural oppression are relevantly linked to the provision of health care in carceral contexts.

In the final section of this paper, then, I draw from critical phenomenology to expand on the complex harms outlined in Poteet's account. The purpose of this analysis is both to shed light on the relevance of critical phenomenology for understanding correctional health care, and to refine and critique further the patterns of abuse, neglect, and structural oppression operating in correctional health care settings.

5. Toward a phenomenological study of carceral medicine

To interpret the harms of the clinical encounter in Poteet's (2001) account of her experience at Danbury, we can draw from resources in the critical phenomenological perspectives described in the previous section of this essay. First, with respect to relational aspects of the clinical encounter, consider Poteet's claim that she has "special needs." The relevance of this is that Poteet is highlighting a potential dysfunction in the therapeutic relationship in the carceral setting. Recall Fanon's statement that the colonial setting produces conditions for heightened distrust and antagonism between patients and providers. In this sense, Poteet's description of her own health care needs as "special" and as an "inconvenience" mark considerations in the therapeutic relationship that exceed those of other patients who receive LEEP procedures. However, as the critical tools from phenomenology highlighted above demonstrate, under contexts of structural violence, including punitive contexts such as carceral settings, many relationships of trust and/or safety between providers and patients break down. Poteet's hesitancy, her "deep breath" before making her request to her gynecologist, frames the expectation for distrust in the clinical encounter. Her discussion about the years of sexual trauma that impact her request for anesthesia is met with "laughs" and probing disbelief. Citing the expectation for a therapeutic relationship, her statement "This is my doctor? I'm quite sure he's not supposed to pressure me to ignore my physical and mental needs by suggesting he'll withhold surgery" marks an explicit breakdown in expectations of healing, trust, and, in her word, "sympathy," let alone basic rules of human decency, compassion, and respect, especially surrounding experiences of trauma.

Building on Poteet's description regarding the lack of trust between providers and patients, several scholars working in the field of correctional health care note what they describe as "dual loyalties" among health care providers. "Dual loyalty," according to Jörg Pont. et al. (2012), "may be defined as clinical role conflict between professional duties to a patient and obligations, express or implied, to the interests of a third party such as an employer, an insurer, or the state. The dual loyalty practitioners most commonly face in prison is between their patients and the prison administration or the state authority" (475). According to Pont and his coauthors, among the dual loyalties that arise in correctional settings are clinicians' participation in body cavity searches; disclosures of the results of blood, urine, or other screenings; forced feedings/forced medications; witnessing use of force/harm to patients; and inmate discipline (such as medical approval for use of a restraint device). Thus, the problem they and other researchers concerned about these dual loyalties of correctional health care providers articulate is that the punitive aims of jails and prisons undermine the therapeutic aims of medicine.

In this sense, Poteet's marking of the use of shackles and strip searches and the framing of her own needs as "merely an inconvenience" to the

carceral system highlight an embodied loss of relationality with her caregivers via the punitive aims of the prison.[11] Rather than expecting the medical encounter, in Fanon's (1965) words, to "pave the way for the peace of [her] body," the physician becomes her "enemy" (123). Rather than an interaction of mutual understanding, what Carel (2014) might consider a more "symmetrical encounter" (54), Poteet views the doctor as a threat that she must battle or from whom she must escape without scarring and further trauma.

In this way, the capacity for a therapeutic relationship is undermined in punitive settings such as jails, prisons, and detention facilities, and the bureaucratic constraints of confinement, criminalization, and control frame caregiving relationships in such institutions. Such relationships are also thoroughly imbricated in the forms of structural oppression that shape mass incarceration and health care in the United States. Consider, for example, how the gynecologist's "laughs" and questions operate as yet another facet of the minimization of sexual trauma and harm that mark the lives of many victims of sexual violence. In this vein, Poteet's own knowledge of her embodied needs are continually overlooked, and the authority of her mental health care provider must be used to offset the doubt, distrust, and negligence of her gynecologist, who appears to be largely invested in serving the needs of the punitive administration.

Second, regarding temporal aspects of the clinical encounter in correctional health care, recall the "interplay" of protentional and retentional possibilities that Guenther (2013) describes in *Solitary Confinement*. Marking both the historical and instantaneous features of the correctional health care setting, Poteet's description of being "lucky" in her clinical interactions is noteworthy. Her invocation of "luck" marks the historical situation of the standards of care for the gynecological health of HIV positive patients, and the epistemic authority and responsibilities that health care professionals bear for their incarcerated patients. This conception of "luck" situates the patient's experiences under the legal and institutional conditions of post-*Estelle v. Gamble* health care systems in prisons. Poteet's description of her location in a post-prisoner's-rights era highlights her expectations for the subsequent standards of care legally and bureaucratically mandated for people who are incarcerated in the United States. In this sense, it is important to note that Poteet's description of the "shame, powerlessness and fear" caused by the gynecological examination emerges under state-sanctioned conditions of health care.

Accordingly, Poteet also notes the protentional possibilities for her embodied needs: that is, that she ought to receive care that affirms her "physical and mental needs" and that she and her physician ought not ignore those needs. Yet, the protentional possibilities that she describes are already framed through the sociohistorical set of medical standards that have been put into place at Danbury, standards that, as she states, the "doctor has probably been following…for so long that to expect him to respond to [her] concerns are laughable." Thus, the sedimentation of prison policies that have ignored or

undermined the kinds of "special needs" that she articulates are structural obstacles that inhibit her aims and desires in the medical setting. Poteet's medical encounter within the carceral system, thereby, highlights the temporal augmentations of correctional health care. Following what Guenther states regarding "prison time," incarcerated patients are expected to ignore, wait, or neglect their own embodied needs for the benefit of the punitive legal and bureaucratic system.

Also with respect to temporality, Poteet's description of her trauma as an "accumulation of events over a long time" marks the cycles of violence that make up the sociohistorical set of possibilities that frame her understanding of her embodied medical needs. At odds with any conception of prior wholeness, Poteet's articulation of her medical encounter is already foregrounded by years of sexual trauma. Her experience of "learning the hard way that most of the people willing to help [her] were predators who got off seeing [her] in pain" impacts her possible intercorporeal interactions with her health care providers. In this sense, the exposure to cycles of violence that is not uncommon for many incarcerated people are, thereby, at odds with the bureaucratic and financial demands of health care settings that normalize patient care around specific class, racial, and gender norms that effectively "anonymize" the embodied needs of patients.[12] Drawing from Carel and Guenther, critical phenomenological approaches to embodied experience can attend to the sociohistorical circumstances by which incarcerated patients become exposed to correctional health care systems, including the structural forms of violence and oppression that exist beyond prison walls.

Poteet's essay also notes the affective and embodied responses to trauma that she experiences in the carceral setting. Alongside her statement that "my body hears only those emotions ['shame, powerlessness, and fear'], no rational thoughts can get through," she is also confronted with an objectifying attitude from the clinician. His statements that "this makes things difficult" and "this will involve paperwork and extra security arrangements" that "may mean we can't do the surgery soon" reduce her trauma to a set of procedural possibilities. Similar to Leder's (2016) description of the "absent touch," Poteet's gynecologist bureaucratically avoids attending to her embodied health care needs. In addition, drawing from Carel and Leder, the clinician's suggestions have the potential to alienate her from her sense of embodied "mineness" in the clinical encounter, effectively reducing her lived body to a passive object and mere disease process. Mineness, in this sense, can be understood, following Mariana Ortega's (2016) reading of Heidegger, as "the individual character of the self in the sense that it registers the self's awareness of its own being, or how the self is faring" (80). Poteet's gynecologist, thus, ask hers to ignore or minimize this sense of mineness and the embodied memories of trauma that such a sense of being bears with it. However, Poteet ultimately rejects this form of alienation and the gynecologist's bureaucratic justifications, and she affirms the relevance of her own "physical and mental needs" in the clinical

encounter. In this affirmation, we can, thus, see resonances of Guenther's (2013) articulation of critical phenomenology that there is "no life without resistance" (xv).

Poteet ends her article with the provocative statement that "botched surgery can give you an ugly scar—a lifetime reminder of how little you are valued. So far, my scars, don't show up on the outside," which point to future temporal and relational possibilities for harm in the carceral setting. That Poteet's scars "don't show up on the outside" may, in this sense, mean that there are no physical signs of abuse from her clinical treatment in prison. Yet, she may also be pointing to the added embodied trauma that may ensue from further degrading treatment and lack of attendance to her needs while incarcerated. That is, reading her "scars" as not showing up outside of the prison may point to a broader claim that the "scars" of potential trauma that "frighten" incarcerated women are those that are not yet understood or engaged "on the outside." There are generations of sexual trauma or perpetual forms of devaluation in medical systems that neglect the needs of poor women and women of color and are, thus, social and historical conditions of embodied being-in-the-world to which critical phenomenology may be able to attend.

To conclude, one final noteworthy aspect of Poteet's account is her relationship with her "shrink." In her article, Poteet points out that her psychologist "doesn't laugh" and "knows that abuse messes you up in invisible ways." Her description here points to the possibility of recognizing the patterns of harm imbricated in forms of structural violence, including the relational and temporal harms that I have described above. It is toward these possibilities of sympathetic listening to the needs and demands of incarcerated people, and toward the elimination of intergenerational trauma inflicted by carceral systems and structural violence that I hope to have contributed. I consider this analysis a small step toward understanding correctional health care as an integral facet of the U.S. carceral system. Likewise, our studies of biomedicine and health care must also attend to the multifaceted features of the social and historical conditions of the modern carceral state. As such, we must continue to mark critically the impasses between the punitive ends of carceral facilities and the therapeutic goals of modern health care.[13] In addition, we must continue to question the degree to which patients, providers, academics, organizers, and other advocates attempting to improve the lives of communities struggling under state-sponsored forms of violence are able to resist the framings of embodied experience that inhibit meaningful caregiving practices, both inside and out of prisons.

NOTES

1. *Editor's Note: Poteet's (2001) blog post is reproduced as written without correction to punctuation.*
2. As a brief caveat, this article is not meant to support the continuation of correctional medicine as a discipline. Rather, my aim is to develop a series of arguments

that contribute to the eradication of carceral systems more generally. As such, I interpret the duties of health care providers and the aims of carceral institutions as generally incompatible. However, that argument cannot be defended in full here.

3. *Estelle v. Gamble* (1976) has been criticized by a number of prison studies scholars due to its narrow interpretation of the evidential standards for proving constitutional rights violations through medical neglect or mistreatment. See Pitts 2014 and Genty 1996.
4. In 2012, a senior official in the ministry of justice in Brazil, a nation-state that has the third highest prison population worldwide, stated that the country would spend 1 billion reais ($500 million USD) on health care in prisons over the following two years. This sum is only 16.4 percent of what the United States spends on prison health care annually (*The Economist* 2012).
5. The public outcry from the fire resulted in a series of investigations into the safety regulations of the prison. See United States Federal Bureau of Prisons (1977) and *Fire Journal* (1978).
6. For more on this distinction, known as the "Leib-Körper distinction," see Guenther 2013; Husserl 1989; Merleau-Ponty 2012; Carman 1999.
7. For another reading of this passage in Fanon, see Pitts 2015.
8. See also Lauren Freeman 2015.
9. The terms "protention" and "retention" in Guenther's reading are drawn from the writings of Husserl and Heidegger. The terms loosely refer to conceptualizations of the relationship between past and future possibilities. More specifically, Husserl's analysis of time consciousness in his 1893–1917 lectures on the topic gave rise to the distinction between "retending" and "protending." For Husserl, these terms are part of the tripartite form of intentionality that constitutes perception, including the "primal impression" alongside "retention," and "protention." Retention is the "primary memory" of the past of an object that accompanies the other two moments of intentionality. Protention is the awareness of future possibilities that attends every act of perception. Heidegger critiques Husserl's conception of time consciousness and attempts to ground temporality in the conditions of an entity that exists in the world. This means that Dasein (literally "there-being," a term used by Heidegger to refer to the entity that is "distinguished by the fact that, in its very Being, that Being is an issue for it") exists in a world of already-given meanings and historical possibilities that, thereby, influence the projected futural conditions for Being. For more on these terms, see Husserl 1991 and Division II of Heidegger 1962. Also for secondary sources on the phenomenology of time, see Zahavi 2003; Brough 1991; Mulhall 2005, and Blattner 2005.
10. I would like to thank an anonymous referee for raising this concern. Also, for extended discussions of similar points in phenomenological approaches to disability, see Garland-Thomson 2011; Wieseler 2016; and Wieseler 2017.
11. Similar examples include persons shackled during childbirth. See Sichel 2007 and Ocen 2012.
12. For an analysis of embodied anonymity and disability studies, see Garland-Thomson 2011.
13. This is a quite generous interpretation of the goals of modern health care in the Global North. For critiques of the mutual imbrications of global capitalism and modern health care, see Metzl and Kirkland 2010 and Waitzkin 2000.

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