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Editors

Applying Nonideal Theory to Bioethics

Living and Dying in a Nonideal World

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Chapter 14

A Nonideal Approach to Truthfulness in Carceral Medicine



Andrea J. Pitts

In 2018, Charles Mills, then-president of the Central Division of the American Philosophical Association, delivered a lecture on the “particular urgency” of bringing philosophical “talents and expertise” to the study of race (Mills 2018, 44). Citing the use of the Nazi chant “Blood and soil!” by members of a Unite the Right demonstration in Charlottesville, Virginia, Mills urged his audience to see the relevance of critically interrogating the functions, foundations, and maintenance of structural racism. Throughout his talk, he revisited a theme that can be traced in various places in his writings on critical philosophy of race and political philosophy, namely, the manner in which ideal theory serves as a support for white supremacy. Aligning himself with contemporary work on epistemic injustice, he pointed to the manner in which ideal theory becomes a “deeply problematic methodology ... in a world where social injustice and related epistemic injustice are not the deviations from the norm, not the outliers, but *constitute* the norm (Mills 2018, 44). He argued to an audience of one of the largest and oldest philosophical organizations in the United States, that ideal theory *itself* is a form of epistemic injustice (Mills 2018, 45). To defend this claim, he charted varying fictional and nonfictional examples of utopian and dystopian writings and their accompanying social imaginaries. Such imaginaries, he noted, shape temporal relations to the past, present, and future, and ontological relations regarding what is, what is not, and what might become of our human social predicaments. He then concluded by arguing that ideal theory—in that case, that of John Rawls and Rawlsians—supports what he describes as a *whitetopia*. That is, he argued that ideal theory is a utopic vision in which “white domination is generally denied, and differential white privilege is masked ... through a vocabulary, an iconography, and a normative apparatus that erases the past and present subordination of people of color” (Mills 2018, 51). Mills’s work on these issues,

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then, creates an important opening through which to raise questions regarding methodology, futurity, and normativity with respect to *nonideal* theory, i.e. when nonideal theory is understood as a corrective to whitetopic imaginings.

This present collection of essays may be considered a response to Mills's call for nonideal theorizing, which in the context of this volume, is being examined in the field of bioethics. Mills's address also delves into a theme that is of further relevance to a collective endeavor on nonideal theorizing in bioethics. Specifically, Mills offers a rich subtext about nonideal theory and *genre*. Notably, the beginning of his address includes a lengthy analysis of utopianism and dystopianism in various fictional literary works. Among the examples he provides are novels and short stories by authors such as Edward Bellamy, Martin Delany, W.E.B. Du Bois, Ralph Ellison, Charlotte Perkins Gilman, Pauline Hopkins, Ursula K. Le Guin, Jack London, George Schuyler, and Alison Sheldon. For each fictional text mentioned, Mills spells out the material conditions of racism, sexism, and capitalism that provide the contrasts for speculative, often utopian, worlds without violence, exploitation, and oppression. The overarching commonality here is that "little extrapolation" is needed to demonstrate a utopian vision (2018, 49). Rather, he writes:

That liberation, were it achievable, would be utopia enough. The epistemology of both kinds of work, political tract and novel, is thus fundamentally oriented by the imperative of revealing the dystopic conditions under which the oppressed have to live (Mills 2018).

The commentary on genre here is that differing forms of writing, including science fiction, provide epistemological correctives to misconceptions, distortions, and erasures of whitetopic ideal theorizing.

Similarly, a number of Mills's other works such as "White ignorance" (2007) and *Blackness visible* (1998) contain discussions regarding the epistemological functions of literary works of fiction. For example, Mills describes Ralph Ellison's *Invisible man* as an "epistemological novel" in that the novel's Black protagonist strives to understand which beliefs should be considered correct in a largely distorted world in which white misperceptions abound (Mills 2005, 18). In this vein, Mills's analyses of white ignorance, ideal theory, and liberalism often contain subtle markers that literary works of fiction by people of color, white women, and other marginalized persons have been providing correctives to the patterns of misinformation, indifference, and denial that have been historically perpetuated under white supremacy, heteropatriarchy, and capitalism. For this reason, he argues in his 2018 address that:

For any ideal of social justice to be truly comprehensive, it will have to pay attention to the alternative voices and perspectives of the historically excluded, recognizing how differently their own positioning has historically framed the relation of the utopic and dystopic, and what should appropriately be seen as "ideal" (Mills 2018).

Thus, implicit within Mills's critique is a methodological suggestion to consider fiction, political treatises, and any number of other genres of writing and art to destabilize hegemonic perspectives that bolster ideal theory.

This chapter, then, draws from this methodological suggestion within Mills's critique of ideal theory, and utilizes another literary genre that may serve as a

corrective to the persistence of *whitetopias* within bioethics, namely, autobiography. While work has been done in literary theory to analyze and critique the functions of authorial voicings in autobiography as a genre, first-person testimony continues to serve as an undeniable form of resistance against efforts to contain, control, or cover over the patterned injustices that members of historically oppressed groups confront. Consider, for example, Margo V. Perkins's book dedicated to understanding, in her words,

[t]he different ways [activists of the Black Power movement] use autobiography to connect their own circumstances with those of other activists across historical periods, their emphatic linking of the person and the political in agitating for transformative action, and their constructing an alternative history that challenges hegemonic ways of knowing (Perkins 2000, xii).

Perkins's book examines three women autobiographers of the Black Power movement—Assata Shakur, Elaine Brown, and Angela Davis—and the contours of political autobiography as a distinct genre of writing. She outlines six shared features of activists who participate in creating political autobiographies:

1. the autobiographer will emphasize the story of the struggle over her own personal ordeals;
2. she will use her own story both to document a history of the struggle and to further its political agenda;
3. she will provide a voice for the voiceless;
4. she will honor strategic silence in order to protect the integrity of the struggle as well as the welfare of other activists;
5. she will expose oppressive conditions and the repressive tactics of the state;
6. she will use the autobiography as a form of political intervention, to educate as broad an audience as possible to the situation and issues at stake (Perkins 2000, 7).

Perkins's listed features here highlight the largely collective functions of political autobiography, which thereby serve as correctives to the mass distortions and coordinated patterns of misinformation and doubt perpetuated through the whitetopic visions that Mills describes.

In bioethics, in particular, the political autobiography of Assata Shakur provides a compelling set of narratives regarding the correctional health care conditions of the 1970s. Shakur, a member of the Black Liberation Army who was imprisoned from 1973 to 1979 under charges for first-degree murder of a police officer, writes directly about her experiences with health care professionals during her arrest and confinement, as well as her experiences of pregnancy and childbirth while in state custody. Given the features of political autobiographies that Perkins provides, Shakur's analysis serves as more than the documentation of one person's struggles through political persecution and imprisonment in the United States. Instead, her work, as I seek to honor it here, offers an account of systemic patterns of oppression that remain operative within correctional health care industries today.

With these interpretive strategies in mind, in this chapter I read Shakur's political autobiography as a careful framing of the complicated *nonideal* conditions of

carceral medicine. That is, while mainstream bioethics often highlights the necessity of truthfulness, or veracity, in the context of health care services, little work has been done that examines the patterned forms of oppression, systemic neglect, and the tightly woven relationships between health care and punitive industries that continue to impact communities of color and poor people in the United States. Mainstream discussions of bioethics often highlight the general importance of veracity within the patient-provider relationship, including providers' obligations and constraints with respect to telling the truth to their patients, and, to a lesser extent, patients' responsibilities and concerns regarding truthful reporting to their providers. However, a great deal of this literature largely overlooks how structural barriers to health care—including racial and sexual biases in clinical judgment, inadequate staffing, infrastructure, and accessibility in medical facilities, and institutionally specific constraints—impact the functions of veracity in the provision of health care. Through a discussion of Shakur's autobiography, this chapter highlights structural barriers to health care in prisons, jails, and detention facilities with a focus on the institutionally specific constraints that arise through punitive aims within carceral facilities. As such, this chapter is a response to Mills's methodological suggestion to utilize diverse genres of writing to show the very dystopic conditions in which many people continue to engage with health care and correctional industries today.

To carry out this analysis, I first outline several accounts of the functions of veracity within bioethics, the majority of which make little mention of how structural oppressions, particularly racism, impact the manner in which veracity should be understood within clinical contexts. In the second section, I turn to *Assata: An autobiography* (1987) to examine a series of issues regarding veracity that arise in the nonideal setting of correctional medicine. I argue that forms of deprivation and disciplinary action work in tandem with structural oppressions in correctional health care contexts to radically alter the value and functions of veracity within those settings. Additionally, I support this reading of Shakur's work through empirical research, court cases, and prison abolitionist writings that outline the status of correctional health care in the United States today. I then conclude by returning to a brief discussion of transformative justice as a model for responding to patterns of harm within correctional health care contexts.

14.1 Veracity in Bioethics

A brief survey of major works within biomedical ethics shows that it is quite common to include veracity or truth-telling between patients and providers as a virtue within health care professions.¹ For example, Tom L. Beauchamp and James

¹Although this chapter focuses generally on the patient-provider relationship in the context of correctional health care, I am leaving out a great deal of literature on medical research and veracity.

F. Childress note in *Principles of biomedical ethics* that while the American Medical Association's (AMA) guidelines did not include any discussion of veracity until the 1980 revisions, veracity—when understood as specifying aspects of the guiding principles of autonomy, beneficence, non-maleficence, and justice—“is vital for a strong patient-professional relationship” (Beauchamp and Childress 2001, 283–284). Likewise, Robert M. Veatch in *The basics of bioethics* asserts that “the principle of veracity is an essential characteristic of human action that shows respect,” and he interprets cases involving veracity through an “obligation to tell the truth” (Veatch 76). Additionally, the American Medical Association's Code of Medical Ethics notes that “Truthful and open communication between physician and patient is essential for trust in the relationship and for respect for autonomy” (AMA 2017, 2.1.3). Generally speaking, the AMA, Beauchamp and Childress, and Veatch all frame cases for truth-telling primarily in terms of disclosure, nondisclosure, deception, and lying. When a patient seeks medical care from a professional, for example, the patient gains a special relationship to the clinician wherein the clinician becomes obligated to provide information in a manner that otherwise would not exist between persons who are not so professionally engaged. Additionally, regarding disclosure, much literature in biomedical ethics has been dedicated to interpreting the conditions under which providers must strike a balance between beneficence and non-maleficence when disclosing medical information. That is, a clinician's aim to protect a patient's wellbeing may be weighed against the potential harm caused by disclosing difficult information about a dismal prognosis which may pose “a serious psychological threat of detriment to the patient” (AMA 2017, 79). In fact, it was this issue, in particular, that led the AMA in the early 1980s to attempt to clarify clinical obligations regarding veracity when delivering or withholding medical information.

Generally speaking, however, trust-building and truth-telling, in the context of the patient-provider relationship in these texts appear abstracted, to use Mills's language, from the more *dystopic* conditions in which many patients live. Notably, major works in bioethics such as those of Beauchamp and Childress and Veatch tend to treat the principles of justice, non-maleficence, and beneficence as disconnected from the sociopolitical conditions in which they are being examined. For example, while mentions of racial health disparities are peppered throughout their works, little careful analysis digs into the systemic, patterned forms of injustice, harm, and mistreatment that impact communities of color in the United States. Likewise, rather than analyzing the epistemic dimensions among patients and providers by viewing both sets of knowers as robustly situated within racial, gendered, cultural, and economic conditions, cases of veracity are seen as occurring between characters such as “Dr. Wordsworth” and “Jim Sullivan,” neither of which bear any relation to community dynamics that might impact their epistemological relationships, including patterns of deception or distrust that function within structurally racist

Such work, however, remains important. For analyses of medical research and incarcerated populations specifically, see Hornblum (1999), Victor (2019), and Washington (2008).

and sexist institutions (Veatch 2016, 78). In this case, as in ideal theory, issues of veracity are abstracted from the lived conditions of patients and providers, and a general, neutral epistemic terrain is assumed when debating issues such as deception, lying, or fostering conditions for mutual trust.

In a more extensive study of veracity, Jennifer Jackson raises systemic injustices as *potential* conditions that would impact truth-telling and trust-building in clinical biomedicine (2002). Jackson outlines literature on the ethics of lying and deception within the European canon, and discussions of truth-telling among medical writings from the Hippocratic teachings of ancient Greece to twentieth century discussions of disclosure, informed consent, the use of placebos in clinical research, and patient confidentiality. Jackson examines whether deliberate deception in biomedicine can be, at times, justifiable or morally permissible. She concludes that when making assessments about whether to disclose or withhold a given judgment, clinicians must consider the underlying background conditions in which the moral act is under consideration. She writes:

[T]he general obligations we owe one another, including the duty not to lie, presuppose a background of reciprocity and state protection. Absent that background, as it may be absent in times of civil war, under a tyranny, or even, rarely, if you are suddenly confronted by a direct and violent threat, the general obligations no longer apply (Jackson 2002, 72).

Jackson raises the need for a “background of reciprocity and state protection” that is needed to support an ethical obligation to tell the truth within conditions of biomedicine. The background that she is considering, however, appears as an aberrant possibility, distanced from more general conditions under which a duty to tell the truth would be binding. As such, although Jackson raises the possibility of unjust conditions prefacing ethical dimensions of truth-telling and trust-building in biomedicine, she commits the whitetopic slip that Mills outlines in his 2018 address. Namely, Jackson assumes that background conditions of injustice are *outliers* to a more basic ethical norm rather than *constitutive* of our normative relations to one another. In this sense, although her work covers a wide array of cases and ethicists, she falls into what Mills describes elsewhere as an “idealized social ontology” (Mills 2005, 168). That is, the view she defends “abstract[s] away from relations of structural domination, exploitation, coercion, and oppression,” and assumes an otherwise just terrain from which to make moral judgements (Mills 2005, 168). In Jackson’s work, then, background conditions of reciprocity and state protection are assumed to function in most, or at least, in many cases, which is at odds with interpretations of structural racism, for instance, as the systematic denial of these moral and political goods to people of color.

Some bioethicists, historians, and sociologists, however, have delved into the racial, gendered, cultural, and economic dimensions of how trust is fostered or prevented between patients and providers in clinical contexts. Much of this work, examines the profoundly unjust conditions under which patients and providers are expected to build trust with one another. In much of this literature, the “avoidance and evasion” of issues of race, gender, class, sexuality, and so on are brought into critical light, and examined in terms of the manner in which these forms of neglect,

denial, and doubt, in effect, *perpetuate* oppressions. Annette Dula writes that three public assertions have had such an effect. Combined, these three beliefs end up supporting an idealized, or to use Mills's language again, a whitetopic image of health care in the United States. The three idealizing assertions are:

1. That physician bias and racial stereotypes do not exist,
2. That methodology in disparities research is seriously flawed and therefore useless, and
3. That African Americans need to take responsibility for their poor health (Dula 2007, 57).

"Together," Dula states, "these three assertions weaken the struggle to end the disastrous condition of minority health" (Dula 2007). Such assertions, she defends, are held within broad public narratives, and are also held by a number of conservative think tanks, "corporate-friendly" politicians, tobacco companies, pharmaceutical companies, and other corporate interests who benefit from perpetuating such forms of doubt, individualist responsibility, and denial (Dula 2007, 48).

Along similar lines, John Hoberman examines how perpetual neglect and manufactured doubt bear negative health outcomes for African Americans, and he connects these epistemological patterns, like Dula, to systemic structural injustices. He writes:

American medicine's disengagement from the black population is only one dimension of the much larger racial disengagement that characterizes American society as a whole. Ignoring African Americans or relegating them to marginal status has been a deeply rooted American habit (Hoberman 2012, 4).

What Dula and Hoberman share in their respective works is the general claim that the distorting lenses of systemic racism have a profound impact on all dimensions of the provision of clinical health care. In this sense, despite well-meaning, good-intentioned practitioners, clinicians make judgments that negatively impact their patients of color.

Both authors address, in particular, the 2002 Institute of Medicine's (IOM) report *Unequal treatment: Confronting racial and ethnic disparities in health care*, and the dialogue that grew around it. The report offers an important, though tentative, claim: "Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare" (IOM 2002, 12). Despite the IOM's status as a reliable nonprofit research organization and the report's survey of over 100 peer-reviewed studies, the report drew significant criticism from some health care providers. Dula and Hoberman both cite the work of Sally Satel, an American psychiatrist who spearheaded one such critical response to the report. Of particular concern, the report included language that racial bias, stereotyping, prejudice, and clinical uncertainty *may* impact clinical judgement, and this language created an opportunity for critics to exploit what they read as the faltering nature of the IOM's findings. That is, the report contained hypothetical language about the role of racially-motivated factors in clinical judgments that have a negative impact on patient health. As such, Satel and others deemed the report

dubious and relying on shaky evidence. More directly, Satel and co-author Jonathan Klick, in a 2006 publication with the conservative think tank American Enterprise Institute called health disparities due to race a “myth,” and they claimed that the relative differences in health outcomes, morbidity rates, and mortality rates, result from factors other than race, such as socioeconomic status and geography (2006, 4). Satel also defends a more general view that public attention to racism in biomedicine is a distraction caused by “political correctness” and discourses of victimization that operate within clinical medicine (2002). As such, Satel’s work serves as a rather obvious example of how health care professionals effectively deny and dismiss the available empirical evidence that points toward systemic patterns of oppression impacting patients in clinical settings.

Against this trend, Hoberman notes, the IOM and similar liberal approaches to medical racism appear to hold out hope that the availability of more empirical research will change the patterns of neglect, deprivation, under-/overtreatment, or otherwise distorted judgments that negatively impact people of color within the U.S. health care system (Hoberman 2012). Yet, he and Dula both suggest that something more than empirical research will be needed to counter the misinformation, misperceptions, and indifference within such whitetopic and whitewashing defenses, and they each offer different approaches to tackle these issues. Hoberman defends the need for historical research showing patterns of racism within biomedicine, as well as curricular reform within medical schools that support “introspective activity regarding human emotions and social realities” about racism and bias. He also proposes a new form of “cultural competency” training wherein the behavior of doctors is under direct scrutiny. Regarding this latter prescriptive, Hoberman rejects cultural competence training that views group-level ethnic and/or racial beliefs as “a set of already known factors” (Hoberman 2012, 225). Instead, Hoberman’s model for training clinicians is to interpret seemingly shared Black “traits,” such as a patterned distrust of medical providers, as responses to “a common predicament [that is the] result of slavery, racial segregation, and the history of stressors associated with being black in the United States” (Hoberman 2012, 225). “‘Cultural competence’ educators,” he writes, “should bear in mind that cultural ‘traits’ result from the collective consequences of group experiences that have accumulated over many years” (Hoberman 2012, 225), rather than inherent features of individuals or groups.

Dula’s approach places a prescriptive emphasis on the economic and political incentives that corporations and policy makers have on denying the existence of racial disparities in biomedicine (Dula 2007, 61–62). In particular, Dula argues that patterns of industry deregulation and the further perpetuation of individualizing narratives of responsibility aid corporations, insurance companies, and their political beneficiaries who stand to gain from the widespread neglect of the health outcomes of communities of color in the United States. Dula’s response, then, is to put discussions of the patient-provider relationship within a broader economic and sociopolitical context in which privatized health care systems, major corporations, and policymakers profit from a reduction of resources for and oversight of the health of people of color in the United States. Analyzing health care with these factors at

play, then, will aid in interpreting the motivations and measures necessary to reduce health disparities in the country, she argues.

In the next section, I propose that we combine Dula and Hoberman's approaches by learning more about Shakur's examination of the systemic sociopolitical and economic conditions impacting Black incarcerated patients. Shakur's autobiography contains important historical framings of structural harms operative within correctional health care, as well as attention to the institutional constraints of health care providers in carceral settings. Moreover, Shakur's autobiography, as a political autobiography, offers insight into collective struggles among African Americans with the U.S. health care system, and collective experiences that impact patterns of trust and veracity in a nonideal world.

14.2 Carceral Medicine and Collective Struggle

Shakur begins her autobiography by depicting her interactions with health care professionals. *Assata: An autobiography* opens with a detailed scene describing Shakur's injury and arrest during a shootout with police on the New Jersey Turnpike in May of 1973, and she recounts her interactions with the staff at Middlesex General Hospital who were responsible for treating her after her arrest. From the beginning of the book and throughout, Shakur offers a series of first-hand recollections of her experiences under medical care while in state custody.

Additionally, and following the nonidealized and political themes mentioned above, Shakur's autobiography carefully discusses work among members of various liberation movements, focusing most specifically on the Black Liberation Army. The Black Liberation Army was an underground armed revolutionary movement that grew in numbers following the shift to reformist politics within the Black Panther Party, a shift that many argue stemmed from increased governmental repression and internal party divisions after 1971 (Umoja 1999, 132). However, Shakur, along with Black revolutionary Geronimo ji-Jaga, who was incarcerated from 1972 to 1997 for charges that emerged during FBI operations targeting Black radicals during the 1960s and early 70s, describes the Black Liberation Army as broader than any temporally-bound group of members. Both Shakur and ji-Jaga describe the Black Liberation Army as "a concept" (Shakur 1987, 169; Umoja 1999, 32). This concept, or idea, Shakur describes in the following manner in an opening statement in a 1975 trial for kidnapping charges for which she was eventually acquitted by the jury:

The idea of the Black Liberation Army [BLA] emerged from conditions in Black communities. Conditions of poverty, indecent housing, massive unemployment, poor medical care and inferior education. The idea came about because Black People are not free or equal in this country. Because ninety percent of the men and women in this country's prisons are Black and Third World. Because ten-year-old children are shot down in the streets. Because dope has saturated our communities, preying on the disillusionment and frustration of our children. The concept of the BLA arose because of the political, social, and economic

oppression of Black people in this country. And where there is oppression, there will be resistance. The BLA is part of that resistance movement. The Black Liberation Army stands for freedom and justice for all people (Shakur 1987, 169).

Note, the explicit positions on health care, drug addiction, incarceration, poverty, and the further economic, societal, and political conditions that led to the development of the “concept” of the Black Liberation Army. Like other revolutionary movements during this period, including the American Indian Movement, the Young Lords, the Brown Berets, and the Red Guard, the Black Liberation Army publicly listed their demands for health care and medical facilities that would serve the specific needs of communities of color both in the United States and worldwide.

This radical health care activism was mobilized through the development of community clinics, free ambulance services, food services, as well as, in the case of the Young Lords, through the occupation of Lincoln Hospital in New York, wherein the members demanded better labor conditions for hospital workers, a community-worker led board that would oversee the policies and practices of the facility, better drug treatment programs, improved access to abortion and reproductive health services, a lead-poison detection program, and an end to “health empires” that profit from the illness and death of poor people (Enck-Wanzer 2010, 190). Such demands, as Shakur highlights, stem directly from the lived conditions of the communities impacted by a dystopic lack of basic health care, food programming, and other public health initiatives. In this sense, Shakur’s autobiography outlines her involvement with radical organizations, including many of those listed above, that prefaced health activism as a necessary component of revolutionary change. Notably, Shakur writes of her eventual break from the Black Panther Party due, in part, from her frustration and feelings of demoralization after the Party put on hiatus their free health clinic, Saturday liberation school, and student organizing efforts (Shakur 1987, 230).²

Alongside this broad-based political orientation toward health care activism, Shakur’s autobiography also directs readers to the health care conditions of incarcerated peoples, in particular. This emphasis in her writings, however, should not be surprising, given that the 1970s was also the beginnings of a national prisoners’ rights movement that fought conditions of overcrowding, neglect, and abuse behind bars through the courts and demonstrations orchestrated and/or led by prisoners both inside and outside of prison walls (Chase 2015). Shakur, as well as Angela Davis, George Jackson, Lolita Lebrón, Fred Arispe Cruz, Susan Rosenberg, David Resendez Ruíz, and many other politicized prisoners participated in a series of legal and extralegal challenges to the medical, sanitary, and punitive conditions within prisons and jails. Such challenges aided in the development of a series of reforms, including the AMA’s first audits of the medical conditions within carceral facilities in the United States (Anno 1991, 12; Anno 2001). Shakur’s autobiography thus traces an important time during the history of correctional medicine: the period of roughly 1971–1979. That is, her incarceration spans a crucial period of health

²For a detailed study of the Black Panther Party’s health care activism, see Nelson (2013).

care activism behind bars, as well as landmark court cases and the early stages of institutions that would continue to shape the development and status of correctional health care today. For example, the litigation of cases such as *Estelle v. Gamble* (1976) and *Ruiz v. Estelle* (1980), and the oversight committees of the AMA and the American Public Health Association that would eventually become the National Commission on Correctional Health Care all occurred during this decade. Accordingly, Shakur's detailed accounting of health care conditions during her imprisonment traces a transformative period of U.S. carceral history.

Given the extensive amount of information regarding health care conditions in the many prisons, jails, and hospitals in which Shakur was under state confinement, I have divided her remarks in the autobiography into three broad categories:

1. Comments regarding the mutual imbrication of policing and health care institutions (bureaucratic, legal, security, and surveillance);
2. Comments regarding interactions between health care providers and patients; and
3. Comments regarding pregnancy and childbirth during incarceration.

Each category, I propose, bears significant implications for relations of trust-building and truth-telling within carceral settings, and, as such, offer nonidealized framings of the role of veracity within correctional health care.

14.2.1 Comments Regarding the Mutual Imbrication of Policing and Health Care Institutions

First, regarding the mutual imbrication of policing and health care institutions, Shakur's descriptions throughout the book detail a number of ways in which legal, bureaucratic, financial, and security and surveillance apparatuses are related in ways that intertwine hospitals and medical professionals with punitive and policing institutions. Importantly, this entanglement between punishment and health industries, I argue, has a negative impact on the dynamics of trust and truth-telling in medicine. For example, in the first few pages of the book, Shakur raises this specific issue in a description of her hospitalization at Middlesex General Hospital just after being detained by the police. She is brought to the hospital to treat the gunshot wounds that she received during a shootout with police. Her first description of the hospital notes that the nurses are supervised by police as they are cutting off her clothing to treat her wounds. Also, during this intake process, she is swabbed for gunshot residue and taunted by a physician during a physical examination. He mockingly asks her "Why'd you shoot the trooper? Why'd you shoot the trooper?" (Shakur 1987, 4). She also states that she initially does not provide her name to the nurse who is treating her.

Moreover, the first days of her hospitalization include "Nurses, doctors, and troopers," and law enforcement agents interrogate her between moments of unconsciousness. Their interrogation, she writes, included physical and verbal abuse, and

the police officers strike her, prod her wounds, and put stinging liquid into her eyes (Shakur 1987, 6–8). The investigation of her alleged crime thus occurs during her hospitalization, and her first interactions with medical professionals are closely monitored and interspersed with police officers attempting to receive information that would help them build a case against her. In this sense, Shakur's description might appear to fulfill Jackson's conditions above regarding the absence of "background conditions" that would remove any duty for her to tell the truth. Yet, note that it is not the absence of conditions of "reciprocity and state protection" that are at a loss here. Rather, state presence via the interrogative practices of law enforcement create conditions that impede her disclosure of information to her providers.

She also writes of the hospital as being "glaring white. Everybody i see is white ... [The hospital] is elegant and clearly for rich people. I am probably the first Black person who has ever been in this room. And the only reason i am there is for security. They have sealed off the doors and no one can enter except through the sitting room next door where three state troopers are stationed. Two regulars and one sergeant" (Shakur 1987, 4; 8). Here, Shakur notes that the conditions of her medical care are, rather perversely, *better* than she might otherwise receive as a Black woman in the United States. That is, she is surveilled in facilities that are, on average, better than those available to many Black people in the country. In this sense, Shakur subtly suggests that law enforcement recognizes that there are material benefits afforded to them by their use of this particular medical facility (benefits that would likely not be available in more overcrowded or underfunded community hospitals).

Later, during her incarceration in Middlesex County Workhouse, Shakur writes of being denied, on multiple occasions, visitations with medical specialists and denied equipment necessary to rehabilitate her arm and broken clavicle. She states that she had to pursue a court order to permit her to receive treatment from a physical therapist, although the court order only permitted a specialist from Middlesex County and none were available in that county for treatment at the prison (Shakur 1987, 49). Additionally, she writes of having her clavicle brace taken by security staff because it contained a half-inch metal buckle (Shakur, 57). To return the brace, a bone specialist had to make a case to the prison warden on her behalf (Shakur 1987, 57–58). Furthermore, Shakur's lawyers plead to the presiding judge of Shakur's case to allow her to receive treatment from an OB/GYN of their choosing during her pregnancy while she was incarcerated at Rikers Island Correctional Institution for Women. Throughout her pregnancy, Shakur writes that her preferred physician, Dr. Ernest Wyman Garrett, a Black physician chosen by her attorneys, was often surveilled during their medical examinations by a court-appointed white physician. This arrangement also led to fewer appointments with Dr. Garrett because the court-appointed doctor could not attend their scheduled appointments (Shakur 1987, 141). Lastly, regarding her chosen health provider, Shakur writes of Montefiore Hospital and the Health and Hospital Corporation going to court to prevent Dr. Garrett from delivering Shakur's child, and winning the case on the grounds that "since [she] was a prisoner it was not necessary for [her] to have a doctor of [her] choice (Shakur 1987, 142). However, she protested this decision by demanding that

she would “deliver the baby herself” and refuse all medical service by the hospital until Dr. Garrett was permitted to see her and deliver the child (Shakur 1987, 143). Additionally, Shakur writes that there was a demonstration held outside the hospital and a press conference held by Dr. Garrett and her attorney, Evelyn Williams, to demand her “right to choose the doctor who would deliver [her] baby” (1987, 143).

It is important to frame a few significant issues regarding the relationship between health care and punitive industries here. Within the literature on correctional healthcare, this institutional relationship is sometimes framed as a set of “dual loyalties” between health care providers and prison administration or state agencies (Pont et al. 2012). The term refers to competing aims between therapeutic functions and punitive/surveillance functions, and we see the conflicts between these arise through the denial of medical judgments and medical equipment necessary for Shakur’s rehabilitation. Such conflicting loyalties or duties impede the provision of care within correctional facilities, and thereby perpetuate nonideal and dysfunctional settings in which patients receive health care.

Beyond this, however, the scenarios described above, all suggest what Ana Clarissa Rojas Durazo (2006), Dean Spade (2015), Alan Berkman (2003), and other critics of mass incarceration have described as an intricate relationship between the medical industrial complex and the prison industrial complex (Rojas Durazo 2006). Specifically, Rojas Durazo, writing about the medicalization of domestic violence, states that “a stop at the hospital can lead to criminal charges” (2006, 181). Rojas Durazo writes of the danger in seeking treatment at medical facilities in which police officers and medical providers both become involved in the enforcement of the law and processes of incarceration, detention, and deportation (2006). She states:

The structured goals of the medical industrial complex are to heighten profits, legitimate the state, and maintain the dominance of the western medical model, which, in turn, perpetuates racism, classism, and heterosexism (2006, 181).

What the Young Lords referred to as a “health empire,” Rojas Durazo names as a set of institutions and companies that are “organized and structured to reflect and reproduce society’s class, racial, and gendered hierarchies” (2006). This stance on medical institutions embeds them within the maintenance structures of white supremacy, heteropatriarchy, and capitalism, and thus analyzes medical institutions as complicit and supportive of punitive institutions and the commercial interests sustaining them.

In a similar vein, Spade, analyzing structural forms of harm impacting transgender communities across the United States, describes what he calls “administrative violence” (2015). Administrative violence, as Spade describes in an interview is, “the concept that administrative systems create narrow categories of gender and force people into them to get their basic needs met” (Oswin 2014). For example, Shakur’s classification as a “prisoner, i.e. someone under state custody,” creates the administrative justification for denying her access to choose her OB/GYN. Spade’s interpretation of administrative violence applies to the constraining of access to basic social goods such as health care, housing security, food security, freedom from violence and humiliation, etc., through the enforcement of gender norms, which often severely impact transgender and gender nonconforming prisoners. In

Shakur's case, her denial of access to a provider of her choice occurs through the "ungendering" of prisoners through formal—i.e. administrative—measures of equality.³ That is, as Angela Davis has argued, late twentieth century prison reform often gave rise to a "separate but equal" model for gender-segregated confinement. She writes:

Paradoxically, demands for parity with men's prisons, instead of creating greater educational, vocational, and health opportunities for women prisoners, often have led to more repressive conditions for women. That is not only a consequence of deploying liberal—that is, formalistic—notions of equality, but of, more dangerously, allowing male prisons to function as the punishment norm (Davis 2003, 75–76).

In this sense, Shakur's denial of a doctor of her choosing enacts a formalistic rule regarding health care access in prisons. While prisoners have a constitutional right to health care established via *Estelle v. Gamble* (1976), including access to professional medical judgment and treatment, they do not have a right to a physician of their choosing, as the courts echoed in Shakur's case. As such, despite her pleas to her attorney "to get a doctor that we can trust," and her insistence that "It's very important for a woman to go through the birth experience with people she trusts," she is administratively prevented from receiving treatment from a health care provider that she deems trustworthy (Shakur 1987, 127; 144). While this aspect of medical ethics is complicated and beyond the scope of this paper—i.e. that patient's have a "right" to choose their physician—Shakur is on firm ethical ground about her right to refuse treatment, and she utilizes this strategy as a means to leverage access to the provider of her choice. Since Elmhurst Hospital was concerned about the risk of a lawsuit resulting from her delivery of a child without medical supervision while she was under their charge, she eventually signs a liability waiver on the condition that they allow her to be treated by Dr. Garrett. In this sense, Shakur's understanding of health care policy, law, and gender norms regarding childbirth result in allowing her to access the resources that she needs, despite the actions of the hospital, courts, and security administration.

14.2.2 Comments Regarding Interactions Between Health Care Providers and Patients

Shakur's autobiography provides detailed descriptions of complicated interactions between Shakur and her health care providers. Importantly, she does not present a single-sided view of the relationships she has with her providers. At times, she describes doctors who are cruel, wanton, and careless, and other times, she offers images of sympathetic, concerned, and helpful caretakers. In this sense, her autobiography serves as an in-depth study of the complexities of *nonideal*

³For more on the theoretical resonances of the term *ungendering* in relation to anti-Black racism, see Spillers (1987).

patient-provider relationships under conditions of incarceration. For example, Shakur recounts an interaction with a nurse with a German accent who provides Shakur with a call button that she uses to bring in nurses when police officers are abusively interrogating her (1987, 9–10). The officers are “punch[ing],” bang[ing], pok[ing], and prod[ding]” her while she is being held under police custody at Middlesex General Hospital, and the nurse becomes witness to this abuse and uses medical surveillance and medical judgment to prevent it (Shakur 1987, 9–10). Namely, when one of the troopers asks the nurse to disconnect the call button, the nurse replies “No, there is no way to remove it. If you pull it out, it will just keep ringing in the nurses’ station. She is having difficulty breathing and she needs it” (Shakur 1987, 9–10). Shakur also recounts the actions of two Black nurses who were kind to her during her hospitalization, one of whom brought her three “carefully selected” books during her stay: a book of Black poetry, *Black women in white America* (Lerner 1972), and *Siddhartha* (Hesse 1922) (Shakur 1987, 16). In such cases, Shakur writes of the tenderness of these nurses, and the significance of such forms of care appears to facilitate her interactions with medical providers, thereby creating conditions that might enable the building of trust between them.

Unfortunately, however, a number of other interactions with providers demonstrate that correctional medicine is fraught with unjust and uneven patterns of bias, neglect, humiliation, and physical and psychological abuse. For example, a prison doctor that she visits during her period of incarceration at Middlesex County Workhouse refuses to provide her any treatment to rehabilitate the nerve damage in her arm. He denies her requests for access to materials that might allow her to regain motor control in her hand (e.g. writing/drawing materials, a rubber ball, or a rubber grip). She also states that she has heard that peanut oil may help aid the movement in her arm. After making this request, the doctor replies:

Peanut oil? ... That’s a good one. I can’t write a prescription for that now, can I? My advice to you is to forget about all of that stuff. You don’t need any of it. Sometimes in life we just have to accept things that are unpleasant. You still have one good arm (Shakur 1987, 48).

In this passage, the doctor expresses a condescending tone and refuses physical therapy for Shakur’s injured arm. Eventually, Shakur’s attorney petitions for her to receive peanut oil, a rubber grip, and writing materials; these are approved by the court and permitted to her during her confinement (1987, 49).

Shakur also has an interaction with a prison doctor who knowingly misleads her about her pregnancy and conducts a pregnancy test on her without her consent. She visits the doctor on multiple occasions describing symptoms of drowsiness, dizziness, increased hunger, a growing feeling of debility, and an upset stomach (Shakur 1987, 121–122). Shakur suspects that she may be pregnant, but does not disclose this to the doctor, although she writes that she “dropp[ed] hints” to him about the possibility of a pregnancy (Shakur 1987, 121–122). He diagnoses her with an intestinal condition and returns her to her cell. Eventually, after taking urine samples but failing to disclose the reason for these samples, Shakur is called into the doctor’s office (Shakur 1987, 122). She writes the following about their interaction in the office:

When the doctor called me into his office, i knew he was going to tell me i was pregnant. Instead, he was smug and acted really on the stupid side. He kept making snide remarks and i could tell he was trying to make fun of me. I asked him what was wrong with me and he repeated the same old stuff about a bowel disorder. Then he asked me some questions about my sex life (Shakur 1987, 122).

Shakur responds by stating “Ask your momma about her sex life,” and slams the office door on her way out (Shakur 1987, 122). Later that day, she learns from her attorneys that she is pregnant. Without her knowledge or consent, the physician had disclosed the results of her pregnancy test to the judge (Shakur 1987, 122–123). When she finally confronts the doctor about why he lied and mislead her, she recounts that the doctor stated: “Well, you lied. I just figured I’d get back at you. Anyway, you found out, like I knew you would” (Shakur 1987, 125–126).

At first glance, the actions of these doctors may indeed appear outright cruel. However, beyond the potentially malicious intentions of these providers, Shakur’s interactions with these doctors suggest that her denial of physical therapy, as well as the misleading and deceptive interaction with her provider, result from conflicting aims between punishment and caregiving. Recall the concept of dual loyalties mentioned above. The denial of physical therapy for her arm results from the security constraints of the prison wherein peanut oil, writing materials, and shoulder braces are assumed to pose security risks. Despite the need for these materials, the demands to ensure the maintenance of the security of the prison outweigh the doctor’s therapeutic role in prescribing further care. Secondly, regarding her pregnancy test, the doctor discloses the results of her test to a judge and willfully deceives her about this process perhaps because he knew that the fact of her pregnancy, conceived while she was incarcerated, would serve as evidence that she was violating prison policy. In this instance, the legal and policy-related concerns of the prison override the physician’s decision to treat the patient and to disclose medical knowledge to her about her pregnancy.

These interactions are painful recollections by Shakur that document the mistreatment of prisoners during incarceration and the opportunities for deception and providers withholding medical information from patients. Thus, unlike the conditions of veracity espoused by idealizing bioethicists regarding the role of providers in ensuring honest and transparent interactions with patients, Shakur’s experiences, like those of many incarcerated persons, reflect the overriding values of punishment industries in determining the transmission of medical information.

More generally, the medical encounters in Shakur’s autobiography provide a picture of a very complicated negotiation among incarcerated patients with their health care providers. Although trust must be earned by health care providers outside of carceral settings as well, under conditions of confinement, prisoners must constantly assess the punitive, and often violent ends of prisons, jails, and detention facilities. As correctional health care analysts themselves attest,

To act within the ethic of their profession, [correctional] health care providers must act counter to the prevailing ethic of the location. Between provider and patient, mutual trust and respect must exist in order for the relationship to work, i.e., to provide the support for diagnosis, care and treatment. The inmate must trust that the physician will act only in the inmate’s best interest, will be his/her advocate and will place his/her health needs above all

other considerations. Most providers enter correctional health care with these values, but they are challenged immediately and constantly by the overriding assumptions and norms of corrections (Anno 1991, 55).

Thus, given that providers are often called to report to judges, security personnel, and prison administration alongside their medical roles, these conditions foster an environment for diminishing the capacities for patients and providers to develop what Jackson describes as conditions for mutual reciprocity and respect. Namely, as Pont et al. note, health care providers are often required to assist in the punitive aims of carceral facilities by participating in body cavity searches, disclosing the results of blood, urine, or other tests, engaging in force-feedings or forced administration of medication, or providing health screenings to determine whether a patient is able to be physically restrained (2012). In this manner, the same providers who are meant to uphold a therapeutic role in their relationship with patients are also serving the broader aims of punishment industries: the control and maintenance of persons convicted of crimes.⁴

14.2.3 Comments Regarding Pregnancy and Childbirth During Incarceration

Lastly, we can examine accounts in Shakur's autobiography about her experiences of pregnancy and childbirth while incarcerated. Touching on important issues of reproductive justice, Shakur writes that prior to receiving care by Dr. Garrett, her prison doctor recommends that she abort the fetus, and he suggests that he would deny her treatment for her diagnosed high-risk pregnancy. After informing her that she might miscarry, Shakur tells the physician that she wants to continue the pregnancy and she requests to see an OBGYN, not a general practitioner. She notes that the doctor denies her this request and says

It would be best for everybody concerned if you have an abortion, no matter which way you have it...My advice to you is that you should go to your cell and lie down ... And if you go to the bathroom and see a lump in the toilet, don't flush it. It's your baby (Shakur 1987, 126).

The horrifying unethical and callous remarks of the doctor, as documented by Shakur, lead her to fear that "they were trying to kill [her] baby" (Shakur 1987, 127). It is this interaction with the prison physician that lead her legal team to request a Black doctor who they trusted to ensure the health and wellbeing of Shakur during her pregnancy and birthing process. Importantly, Dr. Garrett testifies on Shakur's behalf to the courts that she required hospitalization as a necessary precautionary measure during her pregnancy, that she could not stand trial while pregnant, and that she should not be shackled during her pregnancy due to the stress and harm caused by this form of constraint.

⁴Shakur recounts an experience of having her vagina and rectum searched by a prison nurse, and the anger and humiliation that it caused her (1987, 83–84).

Also, interestingly, Dr. Garrett plans, if the judge is not persuaded by medical expertise, to publicize the information about her medical treatment at the prison to right-to-life groups, and claim that the prison is effectively “committing murder” of Shakur’s unborn fetus. Here, Shakur’s legal team also demonstrate subtle negotiations of administrative forms of violence that directly and disproportionately impact women of color. In this case, using the language of the “right-to-life” to garner public outcry, Dr. Garrett develops a carefully orchestrated proposal that seems to support the values of what would later become a reproductive justice framework, values which are reinforced elsewhere in Shakur’s autobiography. As a movement formed and led by women of color in the 1990s, the basic framework of reproductive justice, as described through the landmark reproductive justice organization SisterSong, is to defend “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities” (SisterSong 2019). Among the issues addressed through this framework is the discourse between pro-life efforts to repeal and restrict access to abortions, and pro-choice efforts to ensure safe and non-stigmatizing options for people to make an individual decision about whether or not to terminate their pregnancy. Importantly, a reproductive justice framework brings into purview the long history of eugenics and population control efforts through state and medical institutions, including forced sterilizations and selective abortion.

Additionally, as Loretta Ross states, reproductive justice efforts seek to transform the societal conditions of racism, heteropatriarchy, capitalism, anti-Semitism, and religious fundamentalism that have long-sought to diminish the lives and futurity of people of color, queer and trans people, religious minorities, and poor people across the globe (Ross 2006, 54). Within this framing, Shakur’s decision to pursue her pregnancy as an incarcerated Black woman can be placed within a broader historical and social context in which Black women, “women on Native American reservations, incarcerated women, immigrant women, and poor women across the board [have their reproductive behavior] policed by an adroit series of popular racist myths, fierce state regulation, and eugenicist control” (Ross 2006, 61). In this register, Shakur writes in response to the prison doctor’s threat of denying treatment that “this baby was our hope. Our hope for the future” (Shakur 1987, 127). While child-bearing is by no means a mandate or prescriptive within a reproductive justice framework, her statement harkens to her specific desire to pursue her pregnancy and the eventual birth of her daughter as a means to promote the survivability and futurity of Black people. Moreover, recalling Perkins’s definition of the genre of political autobiography, this statement can be read as an illustration of the *political* aims of her memoir “to use her own story both to document a history of the struggle and to further its political agenda” (Perkins 2000, 7). Thus, the collective undertones of Shakur’s plea to her attorney that she needs “a doctor we can trust” speaks to the profound and systemic shared patterns of distrust that mark access to reproductive health care among communities of color, in general, and incarcerated people, specifically (Shakur 1987, 127).

14.3 Conclusion

I have offered here a series of reflections on the relevance of Shakur's autobiography as a corrective to patterns of neglect, denial, and doubt that prevail within ideal-theoretical framings of veracity within bioethics. By charting the mutual imbrication of punishment and medical institutions, as well as the functioning of dual loyalties for practitioners, and the severe impact of the abuse and mistreatment of patients under conditions of confinement, Shakur's autobiography stands as more than mere testimony to a set of nonideal conditions. Rather, her work was and is a call for societal transformation and resistance to structural harms impacting oppressed persons worldwide. When read in this light, trust-building, truth-telling, and veracity in bioethics can be understood as practices and values that uphold or deny those resistant and transformative ends.

To clarify such potential transformations, consider what prison abolitionists describe as "non-reformist reforms," a term that refers to forms of direct action, policy change, and community support that seek to "reduce the power of an oppressive system while illuminating the system's inability to solve the crises it creates" (Berger et al. 2017). Such non-reformist efforts respond to the assumed tension between seeking an end to punishment industries, while also seeking to embetter the lives of those currently suffering under those industries. For example, some critics allege that improving current conditions within prisons and jails may only extend the institutional life of prisons, and increase public acceptance of carceral strategies. Reforms within prison health care, prison programming, and so on are thus viewed as sustaining prison industries. These efforts are distinguished from direct changes that might seek to provide essential services while also diminishing the goals and futurity of punishment systems. On this point, Thomas Mathiesen explores this distinction:

"Reformist" reforms have goals which are subordinated to the facilities and the presuppositions of a system and a policy presented by the adversary. A "non-reformist" reform, however, is not geared to whatever is possible within the framework of a given system, but to that which "should be realizable" in view of human demands and needs. A "non-reformist" reform, in other words, goes beyond the facilities and presuppositions presented by the adversary's system (Mathiesen 2015, 25).

In this sense, we can examine responses to the complicated nonideal conditions of carceral medicine with such non-reformist aims in mind. That is, rather than continue the aims of punitive systems that perpetuate conditions of injustice, an abolitionist framing of carceral medicine creates options forward that do not sustain a notion of the future that includes and relies on carcerality as a response to social problems. Alleviating the harms of the current prison system in the U.S. would require more than simply closing the doors of prisons. Instead, just as the abolitionist project articulated by W.E.B. Du Bois framed the abolition of slavery as a comprehensive project that required both the dismantling of the formal institution of slavery, as well as the construction of *new* institutions that would replace the social

order that was created and sustained via the trans-Atlantic slave trade and its afterlives, prison abolition is also a constructive project (Davis 2005, 92).

One component of such an approach is to delink the relationship between crime and punishment. That is, as Angela Davis states:

“punishment” does not follow from “crime” in the neat and logical sequence offered by discourses that insist on the justice of imprisonment, but rather punishment—primarily through imprisonment (and sometimes death)—is linked to the agendas of politicians, the profit drive of corporations, and media representations of crime (Davis 2003, 112).

One task, then, for bioethicists and health care practitioners, advocates, and activists is to undermine formations of criminality that frame persons convicted or accused of crimes as individual wrongdoers or as less deserving of basic goods and services.

To clarify, one context in which to see such a distinction between reformist reforms versus non-reformist reforms is in the training guidelines and manuals for correctional nursing. Recall Hoberman’s suggestion—regarding how to shift interpretations of racism within biomedicine—included a plan to transform the educational curricula of medical schools. Within such a framing, we could turn to professional organizations and documents that frame the ethical principles and guidelines for their respective professions. For example, Lorry Schoenly offers a chapter on such principles in the collection *Essentials of correctional nursing* (2013). Drawing from the guidelines of both the American Nurses Association and the American Association of Colleges of Nursing, Schoenly outlines the importance of values such as altruism, autonomy, human dignity, integrity, and social justice within correctional nursing (Schoenly 2013, 20–24). Moreover, Schoenly acknowledges the structural barriers to care within carceral settings. She writes:

Caring in correctional nursing practice may be moderated by several environmental factors. One factor is the incongruent missions of nursing and the prevailing security culture in which it is practiced. Nurses must continually negotiate boundaries between the values of custody and the values of caring; continually guarding against co-opting security values in practice. Caring can be difficult in an anti-therapeutic environment (Schoenly 2013, 30).

Schoenly comments here appear to acknowledge the conflicting aims of punishment industries and therapeutic industries within correctional medicine. However, this chapter and the collection in which it is included fails to question the necessity or social functions of prisons, jails, and detention facilities themselves. Accordingly, we find a missed opportunity for correctional nurses to take a politicized stance that seeks to transform the administration and practice of nursing in carceral facilities.

Additionally, much of the remaining literature in the chapter and collection frames correctional medicine as posing *unique* challenges to the practice of nursing. For example, issues like dealing with the conflicting aims of “security culture” and the “missions of nursing” are treated as particular to correctional facilities. Yet, as Shakur’s autobiography attests and Rojas Durazo defends, persons who are hospitalized in any facility can be subject to interrogation and criminalization. In this way, the security apparatus of prisons, jails, and detention facilities are structured in ways that are concentrated and apparent within these institutional settings, but

they are not *unique* to these settings. Rather, as Michel Foucault asks amidst his examinations of the relevant linkages between hospitals, asylums, and prisons:

Is it surprising that the cellular prison, with its regular chronologies, forced labour, its authorities of surveillance and registration, its experts in normality, who continue and multiply the functions of the judge, should have become the modern instrument of penalty? Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons? (1995, 227–228).

From this provocative question, one abolitionist step forward is to reshape medical curricula within the politicized purview of the structuring of carceral power. Medical institutions are not immune or separate from the organizing functions of security, surveillance, and racialized and gendered patterns of criminalization. To assume otherwise is to drift back into a whitetopic imaging that considers the criminal punishment system to be a well-ordered constellation of institutions that protect the needs of the U.S. citizenry. Yet, this assumption could not be farther from the descriptions and demands made by Shakur, the Black Liberation Army, the Movement for Black Lives, and the many other groups who have sought universal access to health care *alongside* an end to police violence, incarceration, and economic exploitation within the U.S. and abroad.

For example, what the Young Lord's described as a "health empire" shifts the frame of medical industries from one of localized neglect impacting primarily Puerto Rican and African American communities in the South Bronx, to one of addressing the broader financial and political interests that benefit from maintaining systemic inequalities in health care, education, and economic mobilization (Enck-Wanzer 2010, 190). The Young Lords condemned the neglect of the hospitals, buildings, and garbage-strewn streets of the South Bronx as a patterned refusal made by wealthy New York administrators and politicians who benefitted from redirecting funds away from these neighborhoods. Similarly, as contemporary activists against environmental racism are pointing out today, lead poisoning within Flint, Michigan has called attention to what Laura Pulido has argued is the devaluation of Black lives and the subordination of Black lives to the "goals of municipal fiscal solvency" (Pulido 2016, 1). Austerity measures imposed within Flint sought to restore financial solvency after the city's General Motors plant polluted the Detroit River as a source for water, and long after the infrastructure of the city had been left to decay. Pulido notes that because many wealthy companies, white people, and the state and federal government had largely abandoned Flint for decades, the story of the city's lead poisoning is one of racial capitalism whereby the primarily Black residents of Flint are treated as expendable surplus populations (Pulido 2016, 10–12). Akin to Dula's recommendations described above, in both of these cases--the South Bronx in the 1970s and Flint, Michigan today—we see scholars and activists demanding health and environmental initiatives that maintain a focus on the policies and benefactors of the systemic medical and infrastructural neglect of poor racialized populations.

In a similar vein, we can turn to an analysis of whitetopic framings within correctional health care. Rather than assuming that a few extra case studies here or

there would shift readers expectations about carceral facilities, or that added nursing staff would resolve the deep structural flaws within carceral medicine, we must reinterpret the function of medicine and health care within the purview of the everyday existence of structural oppressions, including but not limited to capitalism, white supremacy, structural misogyny, ablenationalism, and heteronormativity and transphobia. From this framing, neglect, abuse, and mistreatment in prisons, jails, and detention centers are not aberrations within an otherwise functioning system. Rather, the harms of carceral medicine are the constitutive norms of punishment industries and their affiliated institutions. Regarding veracity, then, creating the trusting relationships among caregivers and those receiving care may require a *politicized* commitment to eradicating systems of oppression. Consider, in this vein, Shakur's relationship with the nurse who demonstrated a commitment to ending the harassment and physical assault that she was receiving at the hands of police officers. The nurse helped build the possibility for trust and truth-telling that might begin to transform the layers of legitimate distrust and skepticism that many people of color have within clinical medical settings, in a subtle gesture of support through the provision of medical staff as a form of protection from further abuse by the police officers who were harassing Shakur. In this way, were major correctional health care organizations and practitioners to develop pronounced stances that went *beyond* the carceral system's own punitive ends, and affirmed the need to abolish such systems through, in Davis's words, "making them obsolete," perhaps we would begin to shift from a whitetopic framing to one of more liberatory potential. For bioethicists and medical professionals alike, then, veracity as a value within the practice of health care need no longer be an abstracted theoretical horizon, but rather, following Mills, "liberation, were it achievable, would be utopia enough."

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