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Walden University

College of Social and Behavioral Sciences

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Charlene Lupo

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Walden University
2022

Abstract

Prison Medical Professionals' Perspectives on Dignity in Death for End-of-Life Inmates

by

Charlene Lupo

MA, Walden University, 2020

MA, American Intercontinental University, 2005

BS, University of Tennessee at Chattanooga, 1995

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Forensic Psychology

Walden University

February 2022

Abstract

Health care requirements of older persons in prison are complicated, and many may require palliative care before their term is completed. The purpose of this qualitative interpretative phenomenological analysis was to explore perspectives on dignity in death for end-of-life inmates through the lens of nine prison medical professionals. Concepts of dignity provided the conceptual framework for the study. Data were collected from one-to-one audio-recorded Zoom interviews and reflective literature articles. Axial coding and thematic data analysis were used to identify five themes: committed to their vocation, lack of services in administering proper health care, institutional barriers prohibiting death with dignity, compassion toward patients as individuals, and recommendations to implement medical and penal system policy and procedures addressing needs of terminally ill incarcerated patients. Findings may contribute to the discussion and positive social change on implementing structured palliative/hospice care within prisons.

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Dedication

This dissertation is dedicated to my heavenly father, Jehovah God. He gave me the strength and fortitude to complete my goal. I also dedicate this work to my family. My daughter, Ladah', my son-n-law, Timothy, and grandchildren, Isaac, Gabriella, and Colin. They stood by, supporting me through this endeavor and have been practicing calling me "Dr. Grandmother" for the past four years. My stepfather, my biggest cheerleader feigning to understand scholarly language such as anthropomorphism.

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Sincerest thanks to my sisters, Lana and Courtnye and my dearest friend, Tracy who always had encouraging words of support and were my champions to complete this journey. When they call now and ask, "what are you doing" they will not have to hear "research." Finally, I would like to acknowledge two dear ladies I met through this process, Tara, and Tiffany. I met these ladies at different residencies, and they have made a huge impact on my life as mentors and academic colleagues.

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Chapter 1: Introduction to the Study

For the undignified and vulnerable inmate, death with dignity can be challenging. Facing a social crisis, the criminal justice system must address the largest cohort of inmates, the older and terminally ill, with their end-of-life journey (Deitch, 2020; Depner et al., 2018; Farmer & Yancu, 2019). Populations such as older and terminally ill life-sentenced inmates are often at a disadvantage in attaining a good death (Sanders & Stensland, 2018). This creates a challenge for the criminal justice system, prisons, and the public health care system to provide a dignified death for older persons in prison during their end-of-life journey while incarcerated (Sanders & Stensland, 2018).

The purpose of the current study was to explore the phenomenon of life-sentenced inmates who are dying or will die while incarcerated through the lens of medical professionals working in prisons. Using a qualitative research method, I explored the interpretative perspectives of lived experiences from the medical professionals offering health care to incarcerated inmates. I used an interpretative phenomenological analysis (IPA) approach as discussed by Smith (2019) to provide a narrative of experiences of the journey from the medical provider's perspective. Data were collected from medical professionals' responses to interview questions and offered detailed experiences rather than an assumed preexisting theoretical perception. I used answers from participants to gain a better understanding of an inmate's ability to die with dignity while incarcerated. Findings may assist policymakers and legislators in creating or revising policies for life-sentenced inmates regarding their care. Findings may also influence decision making on

alleviating current challenges regarding the sentencing structure faced by the penal system bureaucracy.

Humans are a sense-production life form whose lived experiences are analytic and valued. Drawn from fundamental principles such as hermeneutics, phenomenology, and ideography, IPA assisted me with thematic coding analysis of the medical professionals' interview responses. Holding to the concept that an uninterpreted phenomenon does not exist, IPA incorporates concepts from hermeneutics and phenomenology. This allowed me to analyze data by letting them speak for themselves to understand how the experience appears to individuals (see Pietkiewicz & Smith, 2012). IPA is idiographic in its commitment to examining each perspective before moving to more general claims (Alase, 2017). Concepts related to dignity such as integrity, autonomy, empowerment, and respect are associated with feelings of fear, loneliness, and insufficient palliative care during the end-of-life journey are a prime example of such a phenomenon. The experiences are elusive, involving complex subjective interactions that are sometimes difficult to articulate. The results of the current study may fill the gap in the literature regarding the experience of dignity in dying for incarcerated individuals through the lens of qualified medical professionals. Chapter 1 includes the background, problem statement, purpose statement, research questions, conceptual framework, nature of the study, key definitions, research design assumptions, scope and delimitations, limitations, and significance.

Background

Although prisons were never meant to be long-term care facilities or nursing homes, the United States penal system faces this social problem. Data indicated that 300,000 (21%) of inmates in 2018 were considered older (Law, 2020) quadrupling the average age of inmate incarceration. The 1994 crime bill establishing tough-on-crime laws and controlled sentencing spawned mass incarceration experienced by the current penal system. Mandated sentencing, three-strikes-you are-out laws, and no option for parole in federal institutions brought forth the current conundrum. Aging inmates in prison results in prison units overflowing with older and terminally ill inmates (Ofer, 2019). A life sentence means certain death while incarcerated. Associated with the housing of these inmates are prolonged confinement conditions and inadequate personal safety and dignity (Guzman et al., 2020).

A human dignity study for inmates sentenced to life without parole (LWOP) and those suffering from a terminal illness was conducted by Testoni et al. (2020). Testoni et al. used Chochinov's dignity therapy to study inmates' perspectives of dignity during their end-of-life journeys while incarcerated. Findings indicated that characteristics of terminal illness in this population extend beyond physical suffering and include loss of hope and life meaning. Two concepts emerged from the study: family values and the meaning of life. Testoni et al. emphasized that contact with family members restores a prisoner's personal sense of dignity.

Holland et al. (2020) and Kreager and Kruttschnitt (2018) noted the phenomenon of increased death rates in prisons and associated ethical issues regarding

the right to die with dignity. These researchers suggested it was urgent for the Bureau of Prisons to process compassionate release applications for inmates diagnosed with a terminal illness. Both studies indicated the increasing percentage of older inmates in United States prisons. As the number of aging prisoners increases, basic human rights of autonomy, integrity, empowerment, and respect among dying inmates are lost in the bureaucratic operations of the penal system (Kadivar et al., 2018).

Adding insult to injury, the COVID-19 pandemic has increased inmate death rates among the infirm and older population. Bruck (2020) advocated early release of older and terminally ill inmates within Virginia state prisons due to the COVID-19 pandemic. Bruck noted that most at-risk inmates had already served up to 30 or more years of their sentence and were deemed low risk to reoffend or pose a threat to the public according to the Bureau of Prisons. The loss of human dignity would include leaving these inmates in crowded cells with little air ventilation (Bruck, 2020). This policy verges on cruelty and has little to do with rehabilitation (Bruck, 2020). Many of these inmates have families and homes they could be released to with no public safety risk, which would reduce their likelihood of dying from COVID-19. Although some institutions in the United States penal system have released qualified inmates, the lack of human dignity afforded to incarcerated inmates is concerning.

Suggesting the state has a duty to protect prisoners placed in its care, Reichstein (2019) argued that the right-to-die with dignity should be afforded to older and terminally ill inmates along with the right to choose when and how they die. Although much

controversy exists on the right to die, this consideration should be extended to prisoners as well.

The Marshall Project covers thought-provoking issues in the United States criminal justice system. Thompson (2018) discussed documented events of inmates who were diagnosed as terminally ill or had chronic debilitating health issues with minimal time left on their sentences. Compassionate release requests are often denied by the Bureau of Prisons for reasons such as life expectancy is currently indeterminate. Thompson suggested that between the years 2013 and 2017, the Bureau of Prisons received approximately 5,400 applications for early release and only 312 were granted. This account raises questions regarding why inmates who have met the Compassionate Release Program (CRP) application criteria are not granted the opportunity to die at home with dignity surrounded by their family and friends.

Problem Statement

A social problem facing the United States penal system is the largest cohort of inmates, the older population. As the aging population increases, geriatric conditions worsen, resulting in an increase in prisoner deaths (Greene et al., 2018; Handtkea et al., 2017). Integrated among this population are 206,000 inmates serving life sentences who will experience their end-of-life journey while incarcerated (Sawyer & Wagner, 2020). Among this group of inmates are those who have been diagnosed as terminally ill by a physician with less than a year to live and older inmates experiencing conditions such as dementia, Alzheimer's, heart disease, kidney failure, and cancer. Heightened vulnerability of prison conditions in conjunction with the comorbidities among older

inmates necessitates treating this cohort with proper medical health care and palliative care for their end-of-life journey (Handtkea et al., 2017).

A nation's character is measured by how it treats its most marginalized citizens (Atkins, 2020). Americans generally believe there should be death with dignity, it is virtually entrenched in the cultural mindset. The penal system in the United States has a different focus and is ill prepared to meet the demands of dying inmates (Hurst et al., 2019). Acute challenges facing this cohort are the protections of life and bodily integrity for inmates because they are the state's responsibility (Prais, 2019). Minimal epidemiological data have been found to support a strategic plan of action addressing the increased number of deaths in prison (Skarupski et al., 2018). Recommendations for alleviating prison overcrowding are copious, while research on the psychological and physical effects of this segment of the prison population is limited (Gaines et al., 2020). Scholarly focus on mass incarceration from Europeans is considerable while this topic in the United States has received insufficient scrutiny warranting further research on this topic (Jouet, 2019).

Chronic medical issues and terminal illnesses are prolific among this population according to Skarupski et al. (2018). A lack of palliative care, trained staff, and funding for the associated medical costs has left this group without substantive respect and dignity during their end-of-life journey. Psychological depression is exacerbated when these inmates are segregated and isolated from the general population (Skarupski et al. (2018). Medical professionals are not legally obligated to provide respect and dignity when caring for prisoners, but they are morally bound by virtue of the oaths they have

sworn. Treatment concerns with dying inmates in prisons involve moral, ethical, and human rights issues (Maschi et al., 2015). A change in community perception may be created generating meaningful responses to aging and dying prisoners before the support of family and loved ones' experiences are considered.

Purpose

The purpose of this qualitative IPA study was to explore the perspectives of medical professionals working with prisoners regarding the end-of-life journey of inmates they treat. I used a descriptive approach to explore perspectives and experiences of medical professionals working with dying inmates. A descriptive design was appropriate to code medical professionals' responses to interview questions. Although countless journal articles have focused on palliative care for prisoners, there was limited research in the United States on the perspectives of medical professionals related to inmates' ability to die with dignity. Further research in this area was necessary. For the current study, I designed an interview protocol to gather data whereby participants had the ability to express their perspectives in a narrative approach. This study was intended to fill a gap in the literature. The emotional pain, loneliness, loss of self-respect, and violence experienced by inmates during their end-of-life journey have been overlooked and understudied (Smoyer et al., 2019). Research with medical professionals providing palliative care while ensuring dignity to inmates did not appear to be a focus in medical, psychological, and criminal justice literature despite the fact there have been large numbers of individuals in the United States affected by the problem (McParland & Johnston, 2019).

I explored the perspective of medical professionals by documenting their experiences. This process was intended to improve the understanding of viewpoints regarding dignity during inmates' end-of-life journey. With a better understanding of death and dignity provided by this study, policymakers may consider positive changes for granting CRP and Medical Release Program applications (Farmer & Yancu, 2019; Thompson, 2018). Only inmates who pose no safety threat to the public should be allowed early release (Cox & Betts, 2021). Improved understanding of the personal perspectives from medical professionals working with these individuals was intended to fill a gap in the literature regarding the end-of-life journey for dying inmates.

Framework

The focus of this study was the perspective of prison medical professionals regarding life-sentenced inmates who are currently experiencing or will experience the end-of-life journey while incarcerated. Using a qualitative research method, I explored the lived experiences of inmates according to the medical professionals offering health care to them. Using an IPA approach as discussed by Smith (2019) allowed me to explore inmates' experiences of the journey from medical providers' perspective. The data derived from medical professionals and peer-reviewed research articles addressing real-life events of dying inmates offered detailed experiences rather than an assumed preexisting theoretical perception. IPA recognizes humans are a sense-production life form and allows for the exploration of lived experience in its own terms in which analytic depth is valued over breadth. IPA is idiographic in its commitment to examining each perspective before moving to more general claims (Alase, 2017). IPA is a helpful strategy

for analyzing issues that are perplexing, questionable, and emotional. Concepts related to dignity such as integrity, autonomy, empowerment, and respect are associated with feelings of fear, loneliness, and lack of palliative care during the end-of-life journey are a prime example of such a phenomenon. Concepts are elusive, involving, complex, and subjective interactions that are sometimes difficult to articulate (Smith & Osborn, 2015).

The research questions were designed to elicit detailed responses from prison medical professionals regarding their interactions with dying inmates. Participants offered comprehensive responses to the interview questions expounding on inmates' dignity in death while incarcerated at their facility. Premised on the notion that human dignity is a value and a right for all individuals, participants with 3 years of working experience with dying inmates were interviewed to fill a gap in the literature (see Kadivar et al., 2018).

Research Questions

Research Question (RQ): How do medical professionals describe their experiences regarding dignity in the end-of-life journey of inmates?

RQsub1: According to the medical professionals, how might the penal system employ factions that support dying with dignity for end-of-life journey inmates?

RQsub2: According to medical professionals, how do life-sentenced inmates come to terms with feelings of loneliness and fear during their end-of-life journey?

Nature of Study

I used a qualitative approach addressing the phenomenon of dying with dignity while incarcerated. Interviews were conducted with qualified participants, and data were

coded and themed. Participants were encouraged to express their personal perceptions and to explain life experiences encountered during their professional career. Participants were recruited through social media, Facebook, and the Walden participation pool. Inclusion was based on the medical professional's years of hands-on experience in treating terminally ill and older inmates during their end-of-life journey within a prison setting.

Given that the concept of dignity in death has been poorly defined, understanding the experiences associated with dignity in death while incarcerated through the lens of professional prison medical professionals was intended to fill a gap in the literature. This study was conducted to improve understanding of the lived experiences of dying inmates according to medical professionals who treated them (see Neubauer et al., 2019). Based on analysis of responses to the interview questions, the emergence of themes characterized the central issue concerning an inmate's ability to die with dignity while incarcerated as perceived by prison medical professionals. The concept analysis of human dignity for dying inmates offered supporting data to future studies and may promote legislative changes concerning sentencing reform and cruel and unusual punishment. Obtaining an understanding of inmates' personal perspectives of dignity in death while incarcerated as interpreted by professional prison health care workers could be beneficial to further research.

Definition of Terms

Compassionate Release Program (CRP): A federal program initiated in 1984 allowing for terminally ill eligible inmates to die outside of prison (Holland et al., 2020). Some states use early medical release of medical parole in lieu of CRP.

Human dignity: All humans regardless of gender, class, race, religion, abilities, or any other factor other than them being human hold a special value tied to their humanity (Soken-Huberty, 2020).

Life sentence: A lengthy sentence usually between 25 and 30 years with the possibility of parole from incarceration (Taylor, 2018).

Life without parole (LWOP): A sentence given to a convicted felon with no chance of parole with the only release option being commutation (Leigey & Schartmueller, 2019).

Assumptions

As the researcher, I assumed that medical professionals would want to participate in this study. Participating would require an hour or two of their personal time for a verbal interview regarding their experiences in working with dying prisoners. Because these individuals are medical professionals with at least 3 years of hands-on experience, there was no monetary or professional gain obtained for participating. I also assumed that health care professionals who chose to practice in a prison setting would provide relevant responses to the interview questions. I ensured confidentiality of data to protect each participant’s identity.

Scope and Delimitations

The experiences of inmates dying with dignity while incarcerated were explored through the perspective of prison medical professionals; therefore, inmates, administrative staff, and correctional officers were excluded. This study was limited to the perceptions of prison medical professionals regarding the experiences of dying inmates and whether incarcerated inmates can die with dignity.

Limitations

Interpretive research typically involves the recruitment of participants who fit the phenomenon being studied. Responses given by current participants were limited to their interpretation based on the constraints of the prison environment. Participants in this study might have had different understandings of the concept of dying with dignity and therefore may not have provided meaningful responses to the interview questions. The interview questions were designed to elicit personal experiences and/or perceptions from the participants as to whether a prisoner is afforded the right to die with dignity or can do so within the confines of a prison environment

Significance

The significance of this study was to explore dying prisoners' ability to die with dignity. The concepts of autonomy, integrity, empowerment, and respect were addressed in the study (see Kadivar et al., 2018). According to Smoyer et al. (2019), most data findings regarding dignity in death for the incarcerated were gathered from stakeholders in lieu of inmates themselves. This fact leaves inmates' voices suppressed impeding the possibility of effective intervention. Data in the current study were analyzed from

transcripts of interviews with medical staff supporting the humanistic viewpoint from medical professionals. In the world of forensic psychology, this was a valid study based on perceptions from the medical professionals who treat end-of-life inmates.

Research results may further the insight and information needed by policymakers, legislators, and the Bureau of Prisons in their efforts to deal with this social problem. A surplus of research articles exists regarding older inmates and the CRP discussing the alleviation of prison overcrowding, specifically dying inmates (Wylie et al., 2018). I did not intend to ground the research in the CRP or the Eighth Amendment prohibiting cruel and unusual punishment, but rather sought to explore the perspective of medical professionals regarding incarcerated patients' end-of-life experiences. The factors contributing to the conservation of dignity while focusing on the inmate's end-of-life care are promoting self-respect while simultaneously demonstrating respect toward the patient/inmate (Söderman et al., 2020).

In addition to understanding dignity in dying from the perspective of medical professionals working in prisons, I explored the embedded feelings of loneliness and fear deceased patients may have communicated prior to death. Deitch's (2020) implication of death by incarceration concerning inmates who are sentenced to LWOP indicated no dignity is afforded to them with their end-of-life journey. McParland and Johnston (2019) noted that prisoners' views on death were demoralizing while others in the public often accepted death as inevitable and a natural progression of life. The phenomenon of dying in prison may have psychological effects on the inmate and lingering negative effects on the family. Prison officials and policymakers may gain a deeper understanding from the

study findings. In line with Walden University's position on creating positive social change, findings from this study may support the literature needed for institutional policy and procedure revisions.

Summary

Although there have been strides throughout the justice system to incorporate a higher level of medical assistance to prisoners at the same quality for those in the community, outcomes have been questionable. With no standardization for end-of-life care for the oldest members of the prison population, I sought to fill a gap in the literature to address this problem. Research regarding dignity in death for prisoners indicated that the social and legal systems are ill prepared to meet the needs of dying prisoners and their end-of-life journey (Cipriani et al., 2017; Depner et al., 2018). Chapter 2 provides an in-depth review of literature related to prisoners' end-of-life journey and the ability to die with dignity.

Chapter 2: Literature Review

According to Mandela, “no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones.” Much like the United States population in general, the prison population is aging. Those serving life sentences are experiencing degenerative diseases along with those diagnosed as terminally ill who are completing their end-of-life journey while incarcerated (Avieli, 2021). Shifting quickly from young to old inmates produces prison units overflowing with older and terminally ill inmates (Ofer, 2019). Alternatives would afford older and terminally ill inmates the prospect of dying with dignity, such as the CPR and early medical release created by Congress when federal parole was eliminated (Bennett, 2021). A gap existed as to whether dignity in dying is afforded to inmates while incarcerated. The sensitized climate of human rights concerns, financial constraints, and ongoing neglect suffered by older and terminally ill inmates warrants further compassion protection and palliative care provided by the criminal justice system.

Death in prison is not a new concept; however, the increased end-of-life care of older and terminally ill prisoners warranted attention. Applying best practices to meet the needs of older inmates, recognizing challenges of inmates and personnel, considering prison history and service execution, and cultivating the attitudes of older inmates reflect the growing problem of end-of-life care in prisons. Researchers have been studying the phenomenon of older prisoners and their care for decades. Reed (1978) noted that the fundamental premise of social gerontology is personal aging experiences are socially influenced. Reed also explained that slowing results, a decrease in energy, and several

cosmetic and structural improvements are signs of biological changes associated with later life while sensory processes, cognitive capacity, motor skills, and behavioral capacities all deteriorate. Although the natural process of aging is inevitable for all individuals, Reed suggested that there are aging trends in the inmate population that do not exist in civilian society. Stevens et al. (2018) suggested that serious health issues and geriatric syndromes, such as incontinence, hearing and vision deficiency, and the chance of falling, also include higher incidence of mental health issues including depression among older prisoners. Overall, older inmates suffer from worse health conditions because of accelerated aging.

Search Descriptions

Current (2018–2022) peer-reviewed articles were retrieved from the Walden University online library and Google Scholar. Research addressing the needs of older inmates was retrieved along with meta-analysis studies. Inquiry terms specific to this study were as follows: *elderly inmates*, *compassionate release program*, *aging prisoners*, *psychological distress of elderly inmates*, *death and dignity*, *terminally ill inmates*, *palliative health care in prisons*, and *end-of-life care*. Using these terms and variations of them ensured the saturation of the literature search. Databases used to retrieve relevant literature were Criminal Justice, Sage Journals, ProQuest Central, PsycARTICLES, and ResearchGate along with Google Scholar for open access articles.

Conceptual Framework

Whereas theoretical frameworks comprise one theory, conceptual frameworks are based on elements found in several theories. I acknowledged associated and disassociated

key concepts of dignity considered paramount in the end-of-life journey for older and terminally ill prisoners: autonomy, integrity, empowerment, and respect (see Kadivar et al., 2018). This qualitative IPA descriptive study allowed for findings to reflect the lived experiences of dying prisoners through the lens of medical professionals offering health care to them. Using the IPA approach discussed by Smith (2019), I explored the experiences of the end-of-life journey for dying prisoners from the lens of medical professionals. Rooted in psychology, IPA is progressively being used among scholars within social, human, and health sciences (Pietkiewicz & Smith, 2012).

Relative to real-world situations, the concepts collected from a conceptual framework guide a study and have the propensity for leading to new theories (McGregor, 2018). As suggested by McGregor (2018), there are four models relating to theory development: exploratory, descriptive, relational, and explanatory. Aiming to provide rich, descriptive accounts of the phenomenon under study, I explored participants' interpretations along with data analysis of information stemming from the epistemology reflexivity within the research questions (see McGregor, 2018). Using ideas from a constructivist framework, I based the key concepts of dignity in relation to dying prisoners from the perspective of prison medical professionals. The responses to interview questions reflected experiences of reality formed through personal interactions and perceptions with the world, specifically participant experiences caring for dying prisoners during their end of life while incarcerated.

Review of Research Concepts

Older Prisoners

Although the United States. prison population is in decline, the fastest growing group of incarcerated inmates is older prisoners (Archuleta et al., 2020). Those considered older within the penal system are age 55 and older. To identify the cutoff age for the term *elderly*, Merkt et al. (2020) conducted a systematic review of articles published between 1985 and 2017 supporting inmates' experience of premature aging, also known as accelerated aging, during incarceration. (De Luca et al. and Zhou et al. 2003, 2011, as cited in Merkt et al., 2020) noted that various domains of cognitive functioning shift at different rates over the course of a person's life. Executive functioning is considered to decrease at the age of 50 in the general population and was used to draw an age cutoff (Merkt et al., 2020). Because inmates are often identified as having a history of unhealthy activities related to increased morbidity, they may be more susceptible to cognitive impairment at a younger age (Merkt et al., 2020).

A similar study was conducted with a participant pool of 58 prisoners in North Rhine-Westphalia, Germany with a medium age of 65.5 (Verhülsdonk et al., 2020). Cognitive functioning awareness was assessed using the Mini-Mental State Test and the DemTect test, two cognitive screening devices. Findings suggested a significant number of the inmates had a greater risk of cognitive dysfunction than individuals of the same age who were not incarcerated. Verhülsdonk et al. noted an immediate need for proper care of older cognitively disabled inmates, including regular cognitive assessment and evaluation of cognitive symptoms. The penal system defines an older inmate at this age

because their well-being status is physiologically comparable to individuals on the outside in their 70s (Farmer & Yancu, 2019). Research showed seasoned inmates are especially vulnerable to increased physical ailments such as dementia, cancer, hypertension, kidney disease, and Alzheimer's along with mental health issues (Dulisse et al., 2020; Farmer & Yancu, 2019; Sanders & Stensland, 2018). With the exclusion of juvenile detention facilities and involuntary commitments, confinements such as federal prisons, state prisons, local jails, territorial prisons, immigration detention, Indian country, and military confinements hold 2,224,000 prisoners (Sawyer & Wagner, 2020). An unintended result is prisons have turned into nursing homes. Between 1993 and 2016, the proportion of United States inmates aged 50 and older increased from 5% to 20%, while the number of those age 40 and older more than doubled from 17.9% to 40.4 % Nagin, 2019).

Overcrowding in prisons, a worldwide problem, is a means for disease transmission both within the prison walls and to the public (MacDonald, 2018). For example, an outbreak of multidrug-resistant tuberculosis in New York City in 1989 was later attributed to prisoners who had been provided insufficient care. More recently, though state-by-state research procedures differ, COVID-19 was detected in nearly 200,000 inmates and 46,000 jail employees (The Marshall Project, 2020). Ramifications of poor health and medical treatment for the incarcerated are potentially severe not only for prisoners but also for the community. When prisoners are moved to other institutions or released into the general population, they are more likely to have communicable

diseases like tuberculosis, HIV/AIDS, hepatitis C, and COVID-19, which may be contagious (Zaitzow & Willis, 2021).

Creating an environment in which older inmates are incarcerated is the result of sentencing reforms in the tough on crime bill put into law in the 1990s to decrease reoffending by released prisoners. Mass incarceration stemmed from the core tactics of the war on drugs with harsh sentencing laws and tough correctional practices, which culminated in an enormous increase in jail and prison populations (Jouet, 2019). Punitive sentencing laws such as mandated sentencing, truth-in-sentencing along with three-strikes-you-are-out, and an increase of life sentences has generated a need to address geriatric and end-of-life care for older inmates (Ofer, 2019; Skarupski et al., 2018). The aging in prisons is not only a United States phenomenon; it is also an issue of national concern (Avieli, 2021). As noted by Leigey and Schartmueller (2019), LWOP is an almost exclusive penal concept of the United States while other continents such as Europe, Central America, and South America do not have LWOP yet have life sentences of approximately 20 to 25 years. Results of the war on drugs indicated that although most prisoners serving LWOP are convicted of violent crimes, the Sentencing Report suggested "over 17,000 individuals serving life have been convicted of a nonviolent offense, including 5,000 convicted of a drug offense" (Nellis, 2017).

Emerging as an alternative to the death sentence, the 1970s generated LWOP. LWOP was not a new sentencing law; rather, it was an addition to the current life sentence ensuring no means of parole would be available. A less costly alternative to capital punishment, LWOP was a feather in the hat of the penal ladder sentencing

guidelines (Leigey & Schartmueller, 2019). LWOP also served to usurp discretion from the parole board as their judgment and release numbers for life-sentenced prisoners were in question. It was believed they were releasing prisoners too early, thereby increasing the reoffending rate (Leigey & Schartmueller, 2019). For those prisoners who met requirements of extreme circumstances dictated by Congress, alternatives were put in place such as the CRP or early medical release.

According to research, the number of older prisoners will continue to increase over the next decade, especially in states where the prison population is concentrated (Dulisse et al., 2020). As stated by the American Civil Liberties Union (2012) as cited in Dulisse et al., 2020), the population of older inmates is projected to reach 400,000 by 2030, a 4,400% surge since 1981. Given this pattern, older prisoners continue to remain an understudied group in the criminological literature; therefore, they are essentially the forgotten people from an intellectual perspective. Early release of individual elderly prisoners is a well-established option for lowering costs and aids in providing treatment for older inmates. Aging prisoners would have more access to care outside of state and federal correctional institutions, which would help them with a better quality of end-of-life care (Dulisse et al., 2020).

Life Sentence Without Parole

Disguised as an alternative to the harsh sentencing of the death penalty, LWOP results are the same: death while incarcerated. Prisoners sentenced to LWOP known to inmates as death by incarceration (Deitch, 2020). According to Deitch (2020), since LWOP has grown in popularity in the United States, critics and scholars have started to

question its seemingly inhumane nature. Many prisoners consider life sentences to be worse than the death sentence because with a death sentence inmate are entitled to certain legal rights, which creates hope (Deitch, 2020). LWOP inmates have expressed psychological distress, while death row inmates have commented that they favor the sentence of death over LWOP (Deitch, 2020). The question is whether it is legal for the state to prevent inmates serving LWOP sentences from dying with dignity if they are diagnosed as terminally ill.

Excluding 2020–2021 COVID-19 deaths, the mortality rate in state and federal prisons according to the Bureau of Justice (2001-2019, as cited in Carson & Cowhig, 2020) report from 2016 has increased dramatically. The latest recorded statistics dated from 2001 through 2016 indicated that state and federal prisons reported over 4,117 deaths within their facilities (Carson & Cowhig, 2020). Carson and Cowhig (2020) proposed that although state incarceration dropped 5%, the death rate rose 15% between 2006 and 2016. In 2016, illness-related mortality accounted for 86% of deaths in state jails, cancer accounting for 30% of all deaths, and heart disease accounting for more than half. Between 2001 and 2016, mortality rates of 28% of state prisoners aged 25 and older decreased, while the prisoners aged 55 and older tripled, indicating they had the highest rate of mortality (Carson & Cowhig, 2020).

The immediate needs of dying inmates are not only an issue in the United States but globally as well. While correctional guidelines differ from country to country, Depner et al., (2018) suggested research is emerging from other countries. The countries include, but not limited to, Switzerland, the United Kingdom, Canada, and Ireland addressing the

urgency of end-of-life care for dying inmates. Supported sentiments on aging inmates is a global crisis documented by the National Prison Administration in Europe reporting prisoners over the age of 50 account for 11% of the total prison population in France (Combalbert et al., 2019).

History of Aging Prisoners

Pressing trends for federal corrections today is the steady increase of older prisoners. Budgetary pressures caused by a growing population with more medical needs and related costs of care are a source of concern (Litwok et al., 2020). Litwok, et al. (2020) suggests examination into the evolving landscape of corrections; the relative consequences of drivers influencing growth in older inmates within the federal prison population have evolved over the years. Between 1994 and 1998, significant rises in the frequency of prisoner admissions account for most of the increase in the elderly population.

Between 1972 and 2009, the number of people incarcerated in state prisons surged by 700 %, due to a close embrace of tough-on-crime policies. With many states experiencing overcrowding, escalating jail costs, and widening racial inequalities by the mid-2000s, criminal justice reform became a priority as lawmakers focused on the social and economic costs of mass incarceration (Percival, 2021). As the first repercussions of the “get tough on crime” policies, the cost-efficiency of the criminal justice system was becoming a pressing problem that worried not only economists but also other social scientists and policymakers by the early 1980s. During the 2020 election cycle, the federal crime bill of 1994, which established harsh new criminal sentences and

encouraged states to construct more jails and pass truth-in-sentencing legislation is noted as being another culprit of increased elderly prisoners (Cooper, 2020). The federal stamp of approval for states to pass even tougher anti-crime legislation came with the 1994 crime bill. All states had passed at least one mandatory minimum law by 1994, but the 1994 crime bill urged even tougher rules by legislators and police, to imprison more individuals for longer periods of time (Ofer, 2019). The principle of “truth in sentencing” can be traced back to the determinate sentencing reforms, which began in the early 1970’s as a punitive crime-control approach. A key concept in the effort to strengthen United States sentencing policies was offering clarity, consistency, and certainty in the duration of prison sentences. The sentences were set by legislators, handed down by judges, and served by offenders.

Dying With Dignity

For purposes of this research study, I do not propose to argue whether dying prisoners have or have not the right to choose when and how they will end their lives while incarcerated, but rather, I will explore the concepts of “dignity” and “dying with dignity” while incarcerated. However, there are discussions and research studies on the “rights of prisoners” to choose the “right-to-die” approach. European prisons such as Lawlandia’s prison HMP Noplace, Reichstein (2019) documents in the Lawlandia’s prison, inmates are processed in the facility just as all other European prisons with one exception. After the prisoner is given a mental health examination and is deemed “healthy” the inmate is then given a cyanide pill and instructed they may take the pill at any time (Reichstein, 2019) In the United States, Messinger (2019) offers assistance in

death is often justified by conceptions of dignity and autonomy by choosing whether, when, and how to end one's life; however, there is one significant group of people who are completely excluded from this opportunity, those who are imprisoned. As states consider and pass legislation allowing for assisted suicide in certain situations, will this be allowed for the incarcerated (Messinger, 2019).

"Dignity" has several interpretations with a variety of overlapping definitions associated with human dignity. Each of the definitions derive its meaning from the ontological, anthropological, or political sense in which it is used. Human dignity may refer to the human race's unique status, the privileged capacity associated with reasonable humanity, or an individual's natural rights (Riley & Bos, n.d.). The Human Rights Organization described the basic concept of human dignity as the belief all people hold a special value that is tied solely to their humanity. It has nothing to do with their class, race, gender, religion, abilities, or any other demographic factor other than them being human (Soken-Huberty, 2020). The Catholic Church perceives dignity of a human being as the cornerstone of a moral vision for humanity, and human life is sacred. "We believe that every person is sacred, that individuals are more important than objects, and that every organization should be judged on whether it undermines or improves the human person's life and integrity" (Life and Dignity of the Human Person | USCCB, n.d.). The Mandela Rules (2015) created by The United Nations Standard Minimum Rules for the Treatment of Prisoners, specify all incarcerated individuals have a right to healthcare that meets clinical and cultural expectations. Entry to treatment, particularly

palliative care that supports a dignified, pain-free death, is a human right, according to the Worldwide Palliative Care Alliance (Burles et al., 2021).

Focusing from a deprivation perspective, Avieli (2021) researched aging inmates' inmates wellbeing. Through an IPA approach, Avieli sought to explore the lived experiences of 18 elderly inmates. Using a conceptual framework, the narratives revealed four key findings.

> Like all other older men comparing aging in prison with aging within the community; 'Better than what I have outside': prison as an escape from a life of loneliness, poverty, and delinquency; 'Here I get some respect 'the older prisoner as a mentor; and 'I feel accomplished': experiences of growth and self-discovery as a means for successful aging in prison (Avieli, 2021, p.1).

Reporting in his study, (Avieli, 2021) discussed earlier research conducted by Noujaim et al. (2019) where 70% of older prisoners reported there were certain advantages to growing old in prison such as health-related self-efficacy and older prisoners embracing new habits and strategies in pursuit of better health. Noujaim et al. research study focused on elderly prisoners aged 50 and those who were diagnosed with chronic illness. Face-to-face interviews were conducted with 140 prisoners determining the relationship between emotional support and self-efficacy during incarceration. Several measures used in Noujaim et al. research such as chronic illness, life-sentence, medical care provisions, emotional support, and visits from family or friends. The findings of this research found that emotional support was shown to be inversely linked to poor health-related self-efficacy. The greater emotional support the lower the risk of

poor health-related self-efficacy. Previous research findings with the elderly incarcerated inmate's express feelings of loneliness, anxiety, fear, suggesting isolation associated with depression are comorbid with aging resulting in one or more diagnosed chronic illnesses (Archuleta et al., 2020; Canada et al., 2020; Dulisse et al., 2020).

A research study conducted by Depner et al. (2018) involving elderly diagnosed chronic or terminally ill explored (a) a prison-based end-of-life service that uses inmate peer caregivers, (b) identifying inmate caregiver reasons for involvement, and (c) examining the role of establishing trust and positive relationships in the correctional end-of-life care environment. Inmate-caregivers with a total of 22 semi-structured interviews participated using a consensual qualitative research design to interpret the data. Findings of this study suggested that nurses felt they provided a rare and appropriate adaptation to prison-based end-of-life treatment, noting the many challenges. Findings of this study suggested there were other perceived gains including future inmate-caregiver rehabilitation, correctional medical personnel feeling empowered, and correctional institutions addressing end-of-life care needs, in addition to a vulnerable population having access to patient-centered end-of-life care (Depner et al., 2018).

Prison Health Care

Health problems combined with getting older in prison increases the risk of anxiety and other chronic illnesses as inmates attempt to cope with prison environment (Combalbert et al., 2019). Combalbert suggested an inmate must rely on prison authorities to treat his medical needs; if authorities fail to acknowledge inmate concerns, referrals to medical care will not be met. Such a failure may produce physical "torture or

a lingering death." This was the evils of most concern to the drafters of the Eighth Amendment. In less serious cases, denial of medical care may result in pain and suffering which suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency (*Estelle v. Gamble*, 1976).

Health treatment for prisoners is required by law in both prisons and jails around the United States enforced by federal and state laws. Two Supreme Court rulings; 44 years ago, and May 2011, (*Brown v. Plata*, 2011) are having major ramifications on how health services are offered to prisoners. The United States Supreme Court ruled in (*Estelle v. Gamble, 1976)* that government has a duty to provide medical treatment to prisoners under the Eighth amendment (which forbids cruel and unusual punishment to prisoners) and failure to do so could breach inmates' civil rights. The two legal tests for treatment are (a) when the medical requirement is "critical" and (b) that prison authorities are not "deliberately disrespectful" to the needs of inmates. These requirements do not offer any clarification about how care is provided and subjective (Zaitzow & Willis, 2021). Provision of medical treatment is seen as a condition of incarceration. If solitary confinement is overly harsh or unnecessary for an alleged infraction, it may also be considered a cruel and unusual treatment in violation of one's Eighth Amendment rights.

Frustration about religious values, cultural pressures, and political attitudes have an immeasurable effect on the accessibility of healthcare to incarcerated persons. Nurses' decision-making and practice can be affected by personal and collective judgments on individuals who are imprisoned and whether they receive healthcare (Burles et al., 2021).

Furthermore, facilities, services, and staff availability within correctional environments have impacted the level of treatment provided. Incarcerated inmates are less likely to receive treatment equal to that provided in community hospital systems due to divisive environment of correctional settings. When planning to handle an increasing elderly prison population, one of the most important, but difficult, jobs that prison administrators will be faced with is creating an efficient social environment. (Aday & Maschi, 2019).

Zaitzow and Willis (2021) reasoned overcrowding, insufficient sanitation, and delayed or inadequate medical attention would quickly fan the transmission of diseases in prisons. The prison health-care system is effectively shielded from media oversight, with virtually no transparency, allowing major care failures to go unnoticed (Zaitzow & Willis, 2021). As noted by Scallan et al. (2021) people in custody face challenges to access and ensuring proper health care is a major concern in prisons not only in the United States but around the world. Most prison deaths are caused by illnesses. Alzheimer’s and dementia, both terminal illnesses, are common in people aged 65 and over and exasperated with prisoners.

Prison Health Care Cost

Although most Americans will never see or be enmeshed in the nation’s massive penal system, there are unparalleled costs (economic, social, and ethical) mandating everyone in this country is paying, in one manner or another (Zaitzow & Willis, 2021). Ethnic populations are disproportionately imprisoned and incarcerated—minorities and others of little or no social capital—are often more likely to be sick due to their imprisonment. As a result, the makeup of today’s inmate population, as well as its

relative health status, has been dubbed a “skewed representation of the general population.” This segment of individuals has less access to medical care resulting in co-occurring conditions such as drug abuse, and have more treatment needs when they reach prison (Gaines et al., 2020).

Major implications of actual prison health care costs are lack of uniformity and openness in reporting, worldwide comparisons of prisoner healthcare expenses are now impossible to study (Sridhar et al., 2018; Zaitzow & Willis, 2021). Correctional health care workers are typically required to report to their facility’s correctional leadership rather than the health care leadership. Military-style institutional lines of command, which usually involve an oath to supervisors impose excessive influence and hindrance on health care practitioners as well as require them to disclose patient-related medical information to custodial personnel. The cost of care for elderly and terminally ill prisoner is five times higher in states with a large elderly population (Maine, Florida, West Virginia, and Vermont) than in states with a limited elderly population such as Connecticut, Arizona, and North Dakota (Himes & Kilduff, 2019). Kinsella (2004) suggests expense of health care for aging prisoners is significantly higher than for younger offenders. According to current estimates, incarcerating a person over the age of 60 costs almost $70,000 a year with little or no chronic illness, compared to $22,000 for younger inmates (Kinsella, 2004). One year spent in prison results in two-years reduction of life expectancy according to Maschi et al. (2015) on the well-being of elderly prisons. Exploring the association of this cohort of prisoners and contributing factors of stress, grief, separation, loss, and trauma were conducted using a cross-sectional correlational

design with over 600 inmate participants age 50+ by means of a mail in survey in the Northeastern state prison system. The coping resources inventory, the life stressors checklist revised, and the health-related quality of life survey were used to measure central variables of concern. Findings from this research study reported that older adults in prison often record a history of negative and difficult life events that influence their current subjective rating of physical and mental well-being. These findings may enable prison correctional and medical staff to handle individuals more efficiently, and as a result, more humanely protect their physical and mental well-being (Maschi et al., 2015).

Many inmates in state prisons in the United States die of illnesses (89% of deaths) such as cancer and heart disease being responsible for half of these deaths (Canada et al., 2020). Physical and mental health diseases are much more common in prisoners than in the general population. There is higher prevalence of communicable diseases like HIV/AIDS, Hepatitis B and C, infectious diseases, and mental disorders (Scallan et al., 2021). While the number of inmates imprisoned with minor or nonviolent crimes has decreased, those sentenced to life behind bars continues to make up a large majority of the prison population. The cost is one million per prisoner for those who serve 40 years or more (Jackman, 2021).

Section 1905(a)(A) of the Social Security Act forbids the use of federal funding and programs, such as Medicare, and Medicaid, for medical treatment given to “inmates of a public facility.” In its efforts to prevent states from shifting health care cost of convicted criminals to federal health and disability services, it has had the opposite effect (Bryant, 2020). Medicaid is forbidden from supporting the health treatment of someone

confined to a prison, jail, detention center, or another correctional system unless the prisoner is cared for 24 hours or longer at a hospital establishment outside the prison or jail, according to a federal statute known as the “inmate exclusion” (Olson et al., 2020). Payment is also stopped by Social Security and disability insurance as well and some veteran’s benefits. Even if a suspect has not been convicted but is incarcerated waiting for a trial, Medicaid payments are revoked as soon as they are booked into prison. When an individual is arrested and imprisoned, their Social Security and veterans’ administration payments are terminated 30 to 60 days later, respectively.

Author Wiggins (2021) recounts a personal story from her bother Brad who spent time incarcerated. She reports truth about inmate conditions and procedures can be upsetting and alarming especially relating to health care. Wiggins quotes “Of the many grim stories he (her brother) relayed, I was most struck by the way his prison facility commodified the health of inmates.” Brad’s access to medical services was much more limited when he was in solitary confinement. Solitary cells were only visited once or twice a week by prison medical officers, who slipped medical referral forms under the cell doors. Brad also explained how prescription drugs were only given out on an intermittent basis, if at all, when in the “hole” (Wiggins, 2021).

Hundreds of prisoners are seen by health care providers, who share insight based on their many experiences delivering care for the patient population through a variety of illnesses. They are one of the prominent voices in understanding current treatment experiences and informing the development of a palliative care model for inmates with life-threatening illnesses during their end-of-life journey. A systematic review of data

taken from 2013 through 2017 in which 10 countries (including the United States) were reviewed on prison health care cost which revealed one comparison between India's annual cost per inmate averaged around $5,900.00 whereas, in the United States. spends approximately $29,978.00 per (healthy) inmate (Sridhar et al., 2018).

Professional Standards and Accreditation of Health Care

The philosophy of dignity, especially the concept of dying with dignity, is akin to the concept of autonomy for dying prisoners. As a prisoner, they do not have much choice, so an inmate is restricted on how to spend his/her final days. On the other hand, prisoners do have the same statutory right to medical care as anyone else in the intensive care units of a hospital (Stephens, 2019). International standards define independence the delivery of health care services as a critical element for quality health care in correctional settings, but many prisons fail to meet these standards due to a lack of sensitivity, lingering rules and regulations, conflicting terms of employment for health professionals, or current health care governance structures (Pont et al., 2018). Before the 1960's, the justice system had a tradition of judicial restraint or "hands-off" when it came to prison administration. A variety of violations occurred due to the lack of judicial oversight and court deference to prison authorities, especially around prisoner health care. In certain prisons, inmates were regularly refused even the most basic medical attention and medical treatment. In the landmark 1976 case of (*Estelle v. Gamble,1976)* the Supreme Court upheld federal authority over correctional health care facilities and found that while civil protections are in jeopardy, judges have an obligation, not a right, to interfere (Dodson, 2019). Inmates are entitled to medical services commensurate with current

medical practice and a consistency appropriate beyond responsible clinical standards when they are imprisoned (Olson et al., 2020).

In the United States, there are no universal guidelines about whether health care facilities should be in prisons. The extent and quality of health care offered in prisons vary widely between states and it often falls short of minimum requirements. It is important to note there are accreditation organizations such as The National Commission on Correctional Health Care and the American Correctional Association that offer voluntary accreditation for correctional health care facilities. In legal proceedings where the quality of health care in correctional institutions is challenged, these accreditation requirements are often quoted (Olson et al., 2020). Unlike community clinics and hospitals, where strict enforcements of the Joint Commission Standards are adopted, this is not the case for correctional and prison facilities.

Documented accounts from several state prison systems noted by (Kinsella, 2004) in 1999, the SCI-Laurel Highlands prison in Pennsylvania, which is specially constructed for senior convicts, reported an average health care expenditure of $16,362 per inmate. In other Pennsylvania prisons, the average cost per inmate was $3,000. In one year, the state of North Carolina spent $200,000 on only one elderly inmate at the McCain Correctional Facility. This prisoner underwent open-heart surgery, stents, and stroke therapy. Treatment for the inmate’s heart illness, diabetes, and high blood pressure added to the daily expenses (Kinsella, 2004).

Challenges in Health Care Services for Prisoners

Elderly prisoners encounter several difficulties in their everyday life. Limited access to health care, poor diets, bad food, lack of communication, negative attitudes toward them from the public and other inmates, toxic environment, restrictions on travel and outside communication, and threats to their safety from predator inmates and others are just a few of the issues they face. They also deal with daily deafening noise, bright lights, unreasonable punishments, demeaning strip searches, unending loneliness, devastating homesickness, and a lack of control over trivial decisions are all common occurrences within a prison setting (Zaitzow & Willis, 2021). Prison culture concerns over ensuring security and supervision can limit or obstruct prisoners' timely or complete access to quality health care, including palliative and end-of-life care.

The state is responsible for providing health care in prison. It is about as good as a limited health plan at best. In the worst-case scenario, it is almost non-existent. When a prisoner becomes sick or desires physician or other medical personnel, they must complete sick call form and leave it in the designated box for consideration so that an appointment with the prison's in-house medical staff may be scheduled (Zaitzow & Willis, 2021). Insufficient services for inmate transfer inside and from prisons and affiliated healthcare facility settings; missing or postponed visits due to transportation issues; and refusal to be moved, for a time or indefinitely, to a high-security facility are all considerations that can make it impossible for inmates to access health care (Panozzo et al., 2020). Because of the unusual conditions of incarceration, inmates of terminal chronic illness do not have the option of dying at home, emphasizing the importance of

hospital treatment at the end-of-life journey while incarcerated. The experiences of health care workers who deliver care for inmates in prisons with life-threatening conditions remains widely undisclosed.

A study researching constraints on the end-of-life care for hospitalized prisoners through the lens of medical health care providers revealed staff uncertainty over prison policies of loss possibilities resulting in lost chances to provide quality treatment for dying inmates (Panozzo et al., 2020). Other participants in the study perceived prisoners were compromised in their health decisions because of factors associated with their prison setting. Irrespective of prisoners' security level (minimum, medium, or maximum), participants reported how prisoners were required to move from their prison to a large metropolitan maximum-security prison to enable them to be transferred to and from the hospital for care. This may cause a reasonable individual to conclude the quality of health service as it intersects with the criminal justice system is outside of the usual clinical realm. Clinicians in the study stated they were unsure what they can and cannot do within the realms of a prison setting. Health practitioners know what they need to do to deliver the appropriate treatment within their clinical disciplines and ethical imperatives; however, when it is regarding inmates, they are unclear (Panozzo et al., 2020).

COVID-19 Pandemic

Leading the world with the highest incarceration rate, United States prisons are a breeding ground for newly detected Corona Virus disease more commonly known as COVID-19. The systemic imprisonment clashed with the pandemic, culminating in a

crisis that has overwhelmingly affected elderly inmates (Bradshaw, 2021). The Marshall Project, a nonprofit journal of criminal justice monitored the number of people who have fallen ill and those killed by COVID-19 in prisons and jails around the world as well as within each United States state since March 2020 (Park & Meagher, 2020). One of the first pleas for releasing elderly prisoner population during the pandemic was Jalila Jefferson-Bullock (2020) noting that prisoner infectious outbreaks are 150% more than the public. While no one is immune to the possibly of contracting COVID-19, the elderly and terminally ill prisoner is more susceptible to dying from the disease (Jefferson-Bullock, 2020).

The rate of transmission for contact of COVID-19 is primarily determined by the degree of interaction with individuals as it is a respiratory-borne illness. Inmates who host the virus make cause for a dangerously high-level transmission and vulnerability to the rapid and potentially catastrophic dissemination of infectious diseases, as noted earlier by the historical spread of tuberculosis, influenza, and other transmittal diseases (Montoya-Barthelemy et al., 2020). One of many personal accounts described by family members is of a father, Bartolo Infante. Mr. Infante was housed in a Texas prison, The Barry B. Telford facility located near the Arkansas border. It was at least 150 miles from the family residence making it impossible for frequent family visits (Lewis & Chammah, 2020). The prison notified the family their father had died from COVID-19. The family only became aware of their father testing positive for the disease through an article feed on the social media website Facebook. To further their grief, the family was informed, because they could not afford funeral costs, the Texas Department of Criminal Justice

(TDCJ) would cover the expense and bury their father at the prison cemetery. Maria, the daughter of Mr. Infante, the spokesperson from the TDCJ said “We are just going to give you a picture of him and that’s it” (Lewis & Chammah, 2020). Case studies and personal testimonies affiliated with inmate death due to COVID-19 are countless for families of elderly and terminally ill prisoners.

While great concern and emphasis are researched and documented about the COVID-19 life-threatening effects on the elderly and terminally ill inmate, there is another group highly affected within the system as well. An occupational hazard at best, not limited to correctional officers, but also health care workers, maintenance workers, administrative personnel, state, and county probation officers have shared common space that exacerbates, intensifies, and serves as a source for infectious illness outbreaks (Montoya-Barthelemy et al., 2020; Bradshaw, 2021). Collected data late in 2020 from the Federal Bureau of Prisons and state Departments of Corrections with 89 % of states reporting, the COVID-19 incident ratio was originally greater among personnel than among inmates inside the prison environment (Ward et al., 2021). The rate of case incidences rose more rapidly among detainees, but it has stayed steadily high among workers. COVID-19 was 3.2 times more common in prison personnel than in the public by November 4, 2020 (Ward et al., 2021).

Compassionate Release Program

Whether the issue at hand is early release or a more comprehensive palliative care such as hospice for an inmate during their end-of-life journey remains to be decided. For purposes of this research study there are viable options such as this worth discussing for

this cohort of prisoners. Already in place, these programs offer a humane alternative to dying without dignity while alone and scared in a prison environment. In American prisons, a growing number of inmates with chronic and fatal diseases are serving time and dying. The restriction on elderly and terminally ill inmates dying in prison raises several ethical and financial difficulties, as it denies inmates their autonomy and requires extensive and expensive health-care services (Holland et al., 2020). Terminally ill and elderly prisoners who are vulnerable at best, died by the hundreds during the COVID-19 pandemic and are still dying because mandates that were issued to civilians by the Center for Disease Control (CDC) and the government warning people to avoid gatherings were not enforced for crowded prison/jail facilities (Pettus-Davis et al., 2021).

Policies such as the Compassionate Release Program and medical release which allow for prisoners to be released on humanitarian grounds have been legitimatized by federal and state laws allowing people to die in their own communities for eligible inmates. Unfortunately for those who meet the eligibility requirements to return to society, little is understood about the content of these programs within the United States departments of corrections (Holland et al., 2020). The Compassionate Release Program affords deserving inmates to die in their homes rather than in prison. The program became a federal law in 1984 to mitigate expenses and mortality in prisons due to serious illness or old age, and it has since been implemented by the rest of United States. Inmates in federal prisons must be 65 years old or older, have a permanent or critical medical disorder due to ageing, have suffered declining mental or physical fitness that significantly limits their capacity to work, and have completed at least half of their

sentence to be considered for compassionate parole from federal custody (Holland et al., 2020).

Wardens are the first line of review for the CRP application process by eligible dying prisoners. These wardens denied or failed to address many applications according to the Marshall Project. From March to May of 2020, wardens approved 156 of the 10,940 applications filed from federal inmates (Blankinger & Neff, 2020). Countless stories are retold from family members of loved ones who applied for the CRP but died before they could be released from prison due to bureaucratic processes or denial from the Bureau of Prisons.

With only three and a half years left on his sentence, Kevin Zeich had been given the news from his physician that he had less than that amount of time to live. Fighting cancer, almost blind, and eating very little, he submitted a CRP application. Approved by the Warden of his prison, he was turned down by the Bureau of Prisons stating, "life expectancy is currently indeterminate." Mr. Zeich was serving a 27-year prison term for dealing methamphetamine. He applied for CRP three times, and three times he was turned down. Kimberly, his daughter, received a call on Mr. Zeich fourth attempt at CRP and told he would soon be arriving home in March of 2016 and that she could pick him up at the airport. The very next morning after receiving the phone call the previous day, Kimberly was told by the prison that her father died the night before (Thompson, 2018).

A chance for a dignified death and a practical resolution to high medical costs from state and federal prisons to care for elderly and terminally ill inmates, the CRP initiated by Congress is a viable option. Prisoners who meet requirements of CRP pose

no threat to public safety being released to die at home. Widra (2020) notes CRP applications typically take about six months for the Bureau of Prisons to process pointing out a lack of structured timelines, limited eligibility criteria, a time-consuming screening process, prolonged hearings, third-party veto power, providers' inability to offer a prognosis, parole board members' lack of medial experience, and no standardized protocols for monitoring applicants and decisions warrants this program is under-utilized to the extreme (Widra, 2020).

Although the criteria for compassionate release are varied, they frequently include considerations relating to age, severity of medical conditions, and time served. Inmates must be 65 years old or older, have a chronic or significant physical or mental condition connected to the aging process or terminally ill diagnoses to the point where it is limiting their capacity to operate and function and served at least half of their sentence (Holland et al., 2020). There are, however, differences between the various sorts of policies. Most notably, whereas compassionate release rules are sometimes extended to older folks who do not have terminal diseases, medical parole rules are almost entirely designated for those who are expected to die due to a terminal disease. Despite pleas to release dying inmates from prison, compassionate release regulations are only seldom used, which might lead to an increase of onsite correctional palliative care. With correctional palliative care services now available in several state and federal prisons, some believe that keeping convicted people in prison is more humanitarian than releasing them into the community where inmates may be unable to navigate care for their medical ailments due to a lack of family and financial support (Holland et al., 2020).

Hospice and Palliative Care Programs

Most prisons across the United States have factored in health care to include Hospice and Palliative Care for elderly and terminally ill inmates as part of their operations and standards. However, little is known about their effectiveness (Prost et al., 2020). A misconception may exist between palliative care and hospice care while the two are not intertwined. Palliative care is health and compassionate services provided to people and their families to improve patient control and quality of life while they are dealing with a life-limiting or life-threatening condition, considering medical, psychosocial, and moral needs. Hospice care is another service for the care of those who have terminal illnesses and are nearing the end of their lives. For patients suffering from advanced conditions, both palliative care and hospice care pay heed to holistic levels of well-being.

Imprisoned older adults are accounting for increased deaths with the majority being caused by chronic or fatal illnesses. The justice system faces a “double burden” of aging and dying with elderly inmates. The estimated number of health illnesses for older people in prisons is nearly four, reflecting high levels of multimorbidity such as high blood pressure, asthma, mobility disorders, and heart disease not to mention mental health issues which are prevalent particularly among the elderly (Prost et al., 2020). Emerging research is being conducted on the increased need for hospice and palliative are to address the basic human rights of individuals incarcerated (Burles et al., 2021; Depner et al., 2018; Prost et al., 2020).

Further research being conducted on the unique challenge’s medical health care providers face in trying to facilitate services needed for these prisoners are prison environments, medical cost, and staff needed to provide outside treatment is restricted (Burles et al., 2021). Noted by McParland and Johnston (2019) challenges faced by providers fall into two categories physical barriers and ideological barriers. Prisons can be noisy, cold, with locked doors, and cell space which inhibit proper medical treatment. Also, a mention should be made regarding the lack of beds, linens, and portable oxygen usually in short supply. These shortages become an obstacle to successful palliative and end-of-life care.

Ideological barriers are met with conflicting treatment and custody preferences. This may drastically affect care for inmates. The use of handcuffs and chains as inmates visit neighborhood clinics or hospices, as well as locked doors when they are dying, are reminders of how treatment and incarceration can conflict (McParland & Johnston, 2019). Associated feelings of entitlement from health care workers and correctional staff reflecting sentiments that prisoners are not entitled to “extra” care is a source of great concern for researchers (Macleod et al., 2020). Championing the vision of death and dignity, Hospice was birthed by none other than Cicely Saunders (Wood, 2021) which later was incorporated within the prison setting in 1987. Hospice care started addressing the needs of the end-of-life care for dying inmates.

With a recorded 1,000 prisons in the United States, currently, only 75 offer Hospice for their dying (Coyle, n.d.). Coyle (n.d.) went on to further discuss the aspects that prisoners, based on their sentences and the facilities in which they are housed, may

be faced with death upon entrance. This not only extends to the dying prisoner but to their cell mate. Some inmates live together for decades and when one dies, it is an extreme loss for the other. Additionally, the surviving cellmate is frequently placed in solidarity until an autopsy has been completed regardless of the cause of death (Coyle, n.d.). Through several research studies conducted on the care and outcomes of the Hospice program, inmates note the care they receive is most important to them (Johnston, 2021; McParland et al., 2021; Prost et al., 2020).

According to a new regional study conducted by the European Association of Palliative Care, (McParland & Johnston, 2021) countries vary regarding the use of Hospice. Differing from the United States prison system's attempted response to address the needs of the elderly in prison Australia, Belgium, Czech Republic, France, Portugal, and Slovakia have no prison hospice programs. However, many nations have and utilize programs that enable inmates to petition for compassionate parole at the end of their lives, allowing them to die outside of custody (McParland & Johnston, 2021).

"Approaches to death and dying reveal much of the attitude of society as a whole to the individuals who compose it (Saunders & Clark, 2006, p. 197)." Caring, communicating, declaring, and planning are four basic typologies explaining how hospices communicate with prisoners (McParland & Johnston, 2021). Combatting the realistic cost and security of outside Hospice Care workers, most penal systems are using what is called "inmate care-givers" who volunteer to undertake rigorous hospice training those outside agencies incorporate for their volunteers (Silletti Murolo, 2020). There are several state prisons that incorporate some kind of "extra" provisions of care for the

elderly such as the Fishkill Correctional Facility located in New York City, New York. This facility's objective is to provide a peaceful, healthy atmosphere for infirm inmates specializing in Alzheimer's disease care. Staff in this facility who care for these inmates are skillfully trained in cognitive impairment and dementia related conditions enabling them to see the onset of negative responses not as defiance of prison rules and policies, but as the side effects of this disease (Silletti Murolo, 2020).

There are several other facilities that have taken a proactive response to the terminally ill and elderly inmate with their end-of-life care such as Pennsylvania, Virginia, and Louisiana. Pennsylvania offers a unique approach to this situation by opening a "geriatric ward" from a closed state hospital. The hospital began serving prisoners in need of long-term treatment, wheelchairs, personal care, dialysis, and geriatric attention in 1996. The hospital also provides hospice care, with medical professionals in charge of the patients' well-being, physical assistance (lifting patients) and companionship are provided by inmates. Louisiana, the pioneer for in-house hospice care opened in 1998. Angola's prison, one of the five state prisons in Louisiana offering the hospice program was awarded a Circle of Life Award by the American Hospital Association, the American Association of Homes and Services for the Aged, and the National Hospice and Palliative Care Organization in 2000, and it is state-licensed (Silletti Murolo, 2020).

Conclusion

No one should be left behind when it comes to end-of-life care: Facilitating a human being to die with dignity is an integral part of humanity, and it should be spread

evenly. It should be afforded to the wealthy as well as to those who dwell in the shadows of the prison world where many die alone. Making policies for aging inmates is a difficult task. There are significant research gaps; experiments are either observational or generic and projects are applied without evidence-based evaluation. More robust procedures can be advanced by joint activities and policy decisions based on what is learned about this community (Silletti Murolo, 2020). Hospice offers more than just medical services to prisoners; many hospice workers are also interested in sharing their experiences in the field of specialized palliative care. Others, with the help of prisons and those interested in custodial care, are improving programs to satisfy the need of this community (McParland & Johnston, 2021).

There are advantages for dying prisoners and peer caregivers, as well as for families and the overall environment of the prison. These services have also been shown to be cost-effective and helpful when it comes to providing comfort treatment. Specialized hospice care systems in prisons demonstrate a great deal of promise for strengthening palliative care and hospice delivery (Coyle, n.d.) The problem of providing palliative care and end-of-life treatment for aging prisoners is treated haphazardly by a patchwork of laws and regulations. While a range of programs have been implemented in a small number of prisons, no consensus about the appropriate method of care for aged prisoners has been found (Farmer & Yancu, 2019). The delivery of EOL treatment to the incarcerated is a difficult challenge. Recent research, along with decades of prior research, suggests prison-based peer care services could be a way to lower medical costs and improve quality of life for inmates who are dying. Using healthier inmates to

complement and adjust treatment can help inmates overcome previously documented barriers to EOL care (Depner et al., 2018).

The process of informing governments and the public about prisoners’ rights is long, and nearly impossible to objectively point to a single person who has had a positive impact directly from the Standard Minimum Rules. However, they have gradually become part of the environment in which criminologists, penologists, and lawmakers work (Ellis, 2021). Since international processes and laws are not self-enforcing, prisoner rights (as all human rights) must be protected first and foremost within the legal structures of countries (Ellis, 2021). To support positive social change, enhancing the understanding of key elements of compassionate release policies necessary to informing public opinion, refining statutory language, and assuring timely access and utilization of compassionate release for incarcerated men and women to die with dignity outside of prison confines. For those who would not meet eligibility requirements of compassionate release or medical release requirements, policy and procedures for all federal and state prisons supporting in-house or community-based palliative care or hospice programs can ensure death can be met with dignity.

Chapter 3 investigates research design, methodology, and data analysis procedure. Other items incorporated into chapter 3 include the role of the researcher, participant selection, instruments used in the study along with ethical issues such as trustworthiness, credibility, and reliability of the study.

Chapter 3: Research Method

The purpose of this qualitative IPA study was to explore the lived experiences of life-sentenced older and terminally ill prisoners during their end-of-life journey through the lens of medical professionals caring for them. The goal of this study was to discover whether the concepts of dignity, such as autonomy, integrity, empowerment, and respect, are available to inmates during their end-of-life journey while incarcerated. Findings from this study may support legislative change and sentencing reform processes to aid in the problem of lack of palliative and medical care for the incarcerated dying prisoner. Methodologies including the design, rationale, researcher's role, research questions, data collection, instrument, sampling size and saturation, along with data collection and analysis are described in this chapter.

Research Design and Rationale

RQ: How do medical professionals describe their experiences regarding dignity in the end-of-life journey of inmates?

RQsub1: According to the medical professionals, how might the penal system employ factions supporting dying with dignity for end-of-life journey inmates?

RQsub2: According to medical professionals, how do life-sentenced inmates come to terms with feelings of loneliness and fear during their end-of-life journey?

The purpose of this qualitative study using an IPA approach as discussed by Smith (2019) was to explore the experiences of prisoners' end-of-life journey from medical professionals' perspective. Qualitative research is useful when the research focuses on complex issues such as human behavior and felt needs. IPA is a psychiatric

research approach that focuses on understanding how an individual perceives experiences (Ungvarsky, 2020). Phenomenology was first conceptualized and theorized as a qualitative science methodology by Husserl (1931, as cited in Alase, 2017) to explain the context of people's lived experiences and the nature of those experiences. Rather than stressing how the researcher perceives the incident or how most people will perceive and respond to it, the researcher seeks to explore and comprehend how the experience shaped the person (participant). The findings of the current study reflected the interpretative perspective of lived experiences from the medical professionals offering health care to dying incarcerated inmates.

The interpretivist paradigm holds that truth is multilayered and dynamic, with various meanings for a single phenomenon (Nel et al., 2018). Analysis approaches are used to help readers understand how people perceive and communicate with their social environment. The IPA method was used in the current study because it was suited to answering the research questions. The IPA method is a qualitative analysis method. Interpretative phenomenological interviewing, as a participant-oriented approach, encourages interviewees (research participants) to express themselves and their lived experience stories as they see appropriate, without bias or accusation (Alase, 2017). Qualitative researchers consider how people interpret their experiences. Qualitative research aims to illuminate interpretations that are less obvious. It also aims to look at the intricacies of the social universe, which are inductive and share parallels in terms of discussing what, when, and how, as opposed to how many and how much, as done in a quantitative study (Tuffour, 2017).

Individuals create truth in interaction within their social environments, which is a core feature in all qualitative studies. Humans create meaning when they interact with the world they are interpreting (Merriam & Tisdell, 2016). This allows researchers to make useful inferences and observations based on the data's themes. Given that the concept of dignity in death was poorly defined, understanding the important attributes associated with dignity in death while incarcerated through the lens of medical professionals was intended to fill a gap in the literature. This study was uniquely positioned to help in understanding the lived experiences of dying inmates through the perspective of medical professionals treating them (see Neubauer et al., 2019). The research questions were designed to address whether life-sentenced inmates during their end-of-life journey are availed the opportunity to die with dignity.

Role of the Researcher

In qualitative research, there is often an association between the researcher and the participants, and the researcher's position is important to the interview process. The knowledge gathered from participants in a qualitative study is subjective because it is the participant's personal perspective, and the researcher interprets the meaning of the experience from the participants' responses (Fink, 2000). A researcher's worldview as well as their attitude toward their research study is known as *positionality* (Holmes, 2020). In qualitative research, the ability to transform the text into a presentation of emerging narratives rather than narrations of participants' life stories, while allowing room for interaction among viewpoints, and to grasp content rich enough to be reanalyzed in various ways has serious ramifications to research findings (Karagiozis,

2018). Therefore, a qualitative researcher's analysis strategy is to isolate and classify phenomena/categories during the research process to comprehend and understand the subject matter (Fink, 2000). My epistemological position on the current study was as follows: (a) Data are found within the experiences of individuals who are caring for older and terminally ill prisoners, either as practitioners or as observers, and (b) due to this, I engaged with participants to collect the data for this study.

Upon receiving the Institutional Review Board (Approval # 09-23-21-0761860) confirmation, I facilitated the distribution of participant and consent documents, along with the interview appointment schedule. Contact information of medical professionals licensed as an MSN, RN, or LPN was gathered by me to ensure participants satisfied inclusion criteria. As the researcher, my responsibility was to ensure that all planned interviews adhered to COVID-19 protection standards, which is why interviews were conducted using an alternate form (phone and/or videoconference) rather than face-to face. These measures allowed each research participant ample time to share stories and opinions. This allowed the participant an opportunity to discuss facility acceptance and support in caring for prisoners during their end-of-life journey. Establishing a relationship with the participants, I addressed confidentiality and privacy of the study process during the introduction of the interview. The only recording of the interview was audio to provide for confidentiality and privacy with each participant. The audio-recorded session was transcribed by Sonix, an automated software system. I found that the interviews allowed me to become involved with the data by delving deeper into each participant's story of experiences and capturing distinctions in the narrative.

Rooted in phenomenology, the knowledge gathered from participants in this study was contextual in nature because it was the participant's personal experience, and I interpreted the meaning of experience from the participants' responses. I used the interpretive paradigm because the responses from participants were presumed to be subjective. I used an interpretivist approach to pay attention to and value what participants said to make meaning of the phenomenon being researched. Interpretivism foregrounds the meaning that individuals or communities assign to their experiences. Patterns, trends, and themes should emerge from the data analysis, and the role of the researcher should be to understand real-life situations from the point of view of the participant (Nel et al., 2018).

Methodology

Research entails not only collecting data but also seeking answers to unanswered questions as part of the method of exploring and/or generating new insights. Research methodology is both the collection of methods or rules applied to the study, as well as the principles, theories, and values that support the research approach (McGregor, 2018). This qualitative IPA study was conducted to fill a gap in the literature regarding an inmate's ability to die with dignity during their end-of-life journey. The subject matter of dignity in death for prisoners warranted further research in trying to understand the positive and negative factors affecting life-sentenced inmates during their end-of-life journey to die with dignity.

Participant Selection

For this study, I used purposive sampling for participant selection. This method of sampling concentrates on candidates who have similar features or characteristics (Etikan, 2016). In the current study, the aim was to concentrate on the specific similarities of participants (e.g., work experience) and how they relate to the research subject by using a qualitative approach addressing the phenomenon of dying with dignity while incarcerated. Purposeful sampling is a qualitative analysis method for identifying and selecting information-rich cases to make the most efficient use of available data (Patton, 1990, as cited in Palinkas et al., 2015). This entails locating and choosing individuals or groups of individuals who are informed or competent about a topic of interest (Creswell & Plano Clark, 2011, as cited in Palinkas et al., 2015). To obtain additional participants for data saturation, the snowball sampling technique was used. The purposive sampling approach, which includes snowball or chain sampling, allows the researcher to select participants to learn about the phenomenon (Ravitch & Carl, 2016).

Saturation and Sampling Size

Sampling selections were derived from medical professionals with at least 3 years of working experience with prisoners during their end-of-life journey. Medical professionals' perceptions of inmates' lived experiences were explored to fill a gap in the literature with a humanistic concept focused on empathy and honesty for all they serve. This was based on the premise that fundamental human dignity is a virtue and a privilege for all people (see Kadivar et al., 2018). Considering Groenewald's (2004) suggesting that two to 10 participants or test samples are appropriate for saturation, while long

interviews of eight to 10 people for phenomenological research are sufficient for saturation, a sample size of nine medical professionals meeting the criteria were selected to participate in the study. According to McGregor (2018), sample size depends on the researcher's assessment and judgment to gather the necessary data to reach expected results. Ensuring that sample size is large enough to achieve saturation but small enough for proper analysis, qualitative researchers select three to 30 participants depending on the research objectives, time allotment, resources, and availability of participants (McGregor, 2018). To ensure confidentiality of the participants, names were coded as Participant A, B, C, and so forth. Each code was documented on the interview schedule, and I will delete files containing names, email addresses, and personal information no more than 6 months following the study. Emails will be deleted, and the interview schedule with the participant's name will be deleted from my computer or destroyed manually.

According to Onwuegbuzie and Leech (2007), an essential part of qualitative research is selecting a sampling strategy such as purposive sampling, which was used in the current study. If the goal is not to generalize to a population but to obtain insights into a phenomenon, individuals, or events, as is most often the case in interpretivist studies, then the qualitative researcher purposefully selects individuals, groups, and settings to increase understanding of the phenomenon (Onwuegbuzie & Leech, 2015). In the current study, participants were required to meet the criteria of medical professional (MSN, RN, or LPN; licensed) who had over 3 years of on-site prison care experience for older and

terminally ill inmates going through their end-of-life journey. Participants were recruited from the Walden participant pool and Facebook social media.

The goal of utilizing the IPA process is to create a space for participants familiar with dying prisoners to describe their experiences with the culture of prison environment as well as their experiences with providing health care services to the prisoners. An invitation to join the study was posted on the Walden participant pool and Facebook social media site (see Appendix B). When response to the invitation was verified for inclusion of criteria, I then forwarded the consent form. With the return of the consent form, I scheduled an interview date and time. This will also allow for the participant to ask any questions they may have about the study. The interview was conducted using online media tools such as “Google Meets” or “Zoom” whichever is convenient for the participant. Only audio was recorded of the interview.

Data Collection and Analysis

In qualitative analysis, the researcher acts as the data collector instrument. The researcher formulates the questions, listens to the participants explain their perceptions, collaborates with them to comprehend their meaning, interprets data, and presents the results (Pizzini, 2008). Interviews conducted with qualified participants were themed and coded from the retrieved data. Since I am the instrument of data collection, it is essential that I am transparent at the beginning of the interview with each participant as to my biases, beliefs, and background on the research study.

Triangulation of data from multiple perspectives such as interviews, journal notes and data analysis with Microsoft Excel reduced the effects that the limitations of any one

method will have on findings and conclusions. As the researcher of this study, I coded and themed data. Participants were encouraged to express their personal perceptions and to also explain life account experiences with their patients during their professional career. Enough time is allotted for each participant to answer interview questions at a pace that works well for them and to recount personal case study experiences if so desired. Privacy is of the highest concern for confidentiality of medical professional and the prisoners under their care. The research questions are designed to evoke specific answers from medical health care professionals serving in prisons, allowing them to explain their experiences with dying prisoners. The participants are known to have a detailed approach to the study questions expounding whether palliative treatment is provided and/or is sufficient for a prisoner to understand his end-of-life journey based on their years of experience. The last question of the interview asks the participant if they have any further comments on the topic matter. At the close of the last questions, I advised participants the interview was over and as soon as the interview transcription is complete, they would receive a copy through email to verify and confirm their responses. The participant will then return the transcription with suggested edits or confirmation. If no confirmation is delivered within three weeks of the initial email, the specified interview would have been excluded from the study.

Most qualitative research projects include gathering participants' perspectives, which are then transcribed and analyzed to uncover a narrative or conceptual structure that encapsulates the essence of the event under investigation. Interpretative phenomenological interviewing, as a 'participant-oriented' approach, encourages

interviewees (research participants) to express themselves and their ‘lived experience’ stories as they see appropriate, without bias or accusation. With current COVID-19 restrictions, interviewing participants were conducted remotely using “Zoom” or “Google Meet” and recorded for audio data transcription. Participants were given a pseudonym code A, B, C and so forth once they agreed to participate to respect their privacy for findings documented in chapter 4 of the dissertation. Only audio was recorded of the interview. After the transcription of recorded audio interview was complete, a copy was sent to the participant for verification and/or editing and then returned.

The analysis of data was constructed as follows: (a) Participant transcripts were read and reread looking for themes along with interpretation of narratives; (b) emergent themes were linked and grouped through the process of coding and writing;(c) overarching group of themes were created once all the interviews were coded and analyzed; (d) interviews were read again confirming themes were consistent with most data establishing credibility. Familiar with the data, hand-coding and theming went smoothly, ensuring themes were correct protecting the validity and integrity of the findings.

The redundancy of hand-coding and data analysis using Microsoft Excel application validated the data analysis. Themes, if any, were detected after coding, and no anomalies were discovered. The data analysis was utilized to respond to the study questions on the availability of dying with dignity for prisoners during their end-of-life journey viewed through the lens of medical professionals. The correct and efficient gathering and compilation of data for analysis is a vital component of excellent research.

I developed the instrument, interview questions (see Appendix A) to answer basic concerns about lived experiences and perspectives of medical professionals working in prisons caring for inmates during their end-of-life journey. As the interviewer, I was the main tool for interview data collection. One-on-one recorded (Zoom or Google Meets) platform was used for interview sessions. To ensure that each participant was interviewed the same way and that all relevant information was captured to answer study questions.

Trustworthiness

Just as important as prisoners not trusting staff, administration, and medical professionals, such is the case for the participants working within the penal system wavering from trusting as remote researchers may be viewed with suspicion because they (the participants) have little control over the study findings (Roberts & Indermaur, 2008). In qualitative analysis, trustworthiness is a crucial component. To maintain authenticity, all participants were asked the same questions and were sent a copy of the transcribed interview to edit and or approve for accuracy. Participants were given an introduction at the beginning of the interview informing them at any time during the interview they may stop. Participants were informed that they may refuse to answer any of the research questions. At the end of each interview, I thanked the participants for their time and participation in the study and reminded them of their privacy rights and processes of destroying all contact information within five years. The participant was informed the transcribed interview would be sent back to them via email for their edit or approval and was to be returned within two-weeks.

Credibility

Trustworthiness in qualitative research refers to the systematic rigor of the research design, the credibility of the researcher, the believability of the findings, and applicability of the research methods (Rose & Johnson, 2020). There is a widespread consensus that qualitative inquirers need to establish that their studies are credible and consensus that qualitative inquirers need to establish that their investigations are credible (Rose & Johnson, 2020). Rose & Johnson, (2020) suggested in a qualitative research study, reliability refers to the soundness of the research, particularly in respect to the suitable methodologies used and the way those techniques were used and executed. Reliability calls into question the methodological process' consistency, with the goal of it maintaining relatively consistent throughout time and between researchers and/or procedures involved.

Reflexivity is a core assumption of qualitative work in psychology (and the social sciences in general), but what it looks like and how we execute it are sometimes imprecise and implicit. This makes reflexivity a difficult task, especially for people who are new to qualitative approaches although many people have the attribute of reflexivity (Lazard & McAvoy, 2020). In qualitative research, especially phenomenological research, this is a useful technique. A qualitative researcher employs a reflective mentality when collecting and evaluating data. In other words, the reflective researcher does not just publish the study findings; he or she also questions and explains how they were arrived at. To understand how personal experience and position impact the research process (i.e., subject selection, methodology s), a qualitative researcher must analyze his

or her own personal experience and position. Lazard & McAvoy (2020) suggests that reflexivity necessitates the unraveling of our partial, positioned, and emotional viewpoints. This approach allows us to evaluate our assumptions and make sense of the social environment beyond what we take for granted.

The reflective process is founded on broad concerns such as "what is the research process, and how am I impacting it? Examples include internal dialogue as well as interactions with participants, coworkers, and others, including people who may have different viewpoints from the researcher of the study (Lazard & McAvoy, 2020). The reflective process starts from a different point of view than why are you researching that subject, why did you ask those specific research questions and why do you hold that theoretical/epistemological position, in that it pushes us to analyze why we explore one issue over another (Lazard & McAvoy, 2020).

Reliability

The answers to the interview protocol's questions were recorded verbatim. After I completed the transcription was emailed back to the participants for verification. Prior to any coding or theming of the content, each participant agreed that the transcript was a truthful and accurate representation of their interview. As a result, the information gathered was reliable. In qualitative research, reliability refers to the consistency of replies to numerous coders of data sets. This was improved by taking field notes during the interview, recording the interview, and transcribing the digital data along with intense data analysis.

Biases

As the researcher, I do not propose to bring any concepts, hopes, assumptions, or theories to the study; instead, I started with a clean canvas used the participants' experiences to learn about the phenomena. This required me to manage biases of empathy, compassion, for the terminally ill and elderly inmates and their continuation of being imprisoned when there is no safety risk to the public If at some point during data collection a participant responded with a description or discussion that I was not anticipating, I noted that response of surprise or astonishment and reflected on those feelings of personal biases in order to perform data analysis with integrity and transparency. As a scholar, my perspectives on the topic of study have been influenced by years of experience working in the criminal justice system. This researcher is not in any way connected personally or professionally to any MSN, RN, or LPN associated with prisons or within the correctional systems that house life-sentenced dying inmates.

Ethics

Ethics have long been a topic in social science studies. Complex topics including cultural, ethical, economic, and political phenomena are investigated by social science (Roberts & Indermaur, 2008). Prisoner research is a crucial and priceless source of insight about violence, criminal behavior, and personal experience(s). It is, though, an environment rife with ethical issues. Because of this difficulty, social science analysis must be concerned with "moral integrity" in order to ensure that the research process and results are "trustworthy" and accurate (Mollet, 2011). In keeping with ethics of sensitive data and storage of that data during and after the analysis, a password protected computer

will house the data. The detachable media device, USB that houses recorded interviews is secured in a lock box not visible to anyone other than myself. Storage of data collection will be destroyed within five years from the date of collection. Appreciating the vulnerability of elderly and terminally ill prisoners and the current COVID-19 restrictions within the penal system, this research focused its study from the lens of prison medical professionals who are in daily contact with prisoners and their health care needs.

Conclusion

I explored the IPA of medical health care professionals' experiences on terminally sick and elderly inmates' right to die with dignity in Chapter 3. This part included a rationalization of the design as well as my function as the researcher. A description of the process was also provided. This section covered the method of selecting participants by purposeful sampling. The usage of data gathering instruments was explored using one-on-one interviews to ensure the participants' privacy. Recruitment, participation, and data collecting procedures were also identified. The data gathering plan and data analysis techniques were covered. The issue of trustworthiness was discussed, and I concentrated on the study's credibility, reflexivity, and dependability. I supplied information on how volunteers were safeguarded ethically throughout the study.

Chapter 4: Results

The need for prison palliative care is growing as the prison population ages. Dying in prison is not a new occurrence while dying with dignity for incarcerated inmates seems to be an alien process in the Department of Corrections. Whether the prison service and judicial system are responsible for health care or health authority, there are variables in incarceration health systems (Spycher et al., 2021). These services are constrained by organizational and resource restrictions that limit inmates' access to onsite health care and use of outside health care facilities. Hurley (2020) suggested that human dignity might be lost through the process of dying while incarcerated. The findings of the current study may support legislative change for sentencing reform for terminally ill and older inmates or by incorporating palliative and hospice care for inmates while incarcerated.

Upon receiving approval from the Walden University Institutional Review Board (Approval # 09-23-21-0761860) with an approved research invitation and consent form, I started the process of participant recruitment. The purpose of this qualitative study was to explore whether terminally ill or older inmates could process through their end-of-life journey with dignity while incarcerated. Data were analyzed through the lens of prison medical professionals. The current study findings are presented in this chapter. Chapter 4 also includes discussion on the setting, data collection procedures, data analysis, evidence of trustworthiness, and a summary.

The recruitment of participants through social media sites produced nine qualified medical professionals who had cared for older or terminally ill prisoners. To answer the

following research question and subquestions, I employed a qualitative, interpretive research design in the study:

RQ: How do medical professionals describe their experiences regarding dignity in the end-of-life journey of inmates?

RQsub1: According to the medical professionals, how might the penal system employ factions supporting dying with dignity for EOL journey inmates?

RQsub2: According to medical professionals, how do life-sentenced inmates come to terms with feelings of loneliness and fear during their end-of-life journey?

Setting

Initial participant experiences for this study were to be analyzed from medical professionals within a Louisiana prison. Due to the COVID-19 pandemic, prison systems worldwide underwent a lockdown and were operating with limited staff (Federal Bureau of Prisons, 2020). I was denied access to the medical professionals in the facility. Prisoner visitation was suspended to reduce the volume of traffic entering and exiting prisons at any given moment taking effect in mid-March of 2020 (Novisky et al., 2020). This situation required me to recruit medical professionals through social media. Posting my research invitation on Facebook produced 31 interested medical professionals. After reading the consent form, nine qualified participants volunteered for the study. There were no criteria that restricted participants from outside of the United States from participating in this study. Posting on Facebook allowed medical professionals across the world to respond to my research invitation.

Through email communication, I determined whether the participant satisfied the selection criteria. It seemed many interested individuals did not read the research invitation fully when they contacted me through email offering to participate in the study. After the process of exchanging emails and sending the consent form, some participants realized they were not qualified to volunteer. Some participants, while qualified, declined further participation after reading the consent form. All qualified and willing participants read the consent form and responded in an email with “I consent” or “Agree” to the study.

A Zoom invitation link was sent to the participant with the date and time of the scheduled interview. All interviews were conducted based on the date and time convenient to the participant. Before recording the interview, I reminded each participant that they could leave the interview at any time. I asked each participant, before officially starting, if they had any questions and ensured all concerns were addressed. During the opening greetings, I explained the study and asked if they were ready to proceed.

Due to temporal and geographical disparities, zoom video interview functionality made it comfortable for me and the participant to conduct the interviews. Zoom also provided a safe environment for data collection during the COVID-19 pandemic because social distancing was in full force. Each participant was reminded not to turn on their video camera; only their microphone was needed during the interview. This request offered additional protection of participant identity. We were able to begin the interview process without fear of being overheard because the interview was conducted at the place

the participant chose. There were no personal or organizational circumstances that influenced participants' responses at the time of the study.

All participants had experience caring for dying inmates as a medical professional. Using a semistructured interview process, I ensured that all participants were comfortable using Zoom as a platform for interviewing and recorded only audio. One participant realized her work computer did not have Zoom access; therefore, we tried using Microsoft Teams but then she messaged me she had access to Zoom on her phone and we proceeded. Different time zones did not pose any significant problems other than several emails confirming time differences. Everyone seemed comfortable using Zoom for recording the interview. Transcript review for each interview transcript went smoothly. Few edits were made by the participants.

Demographics

Participants in this study were recruited from Facebook groups. To preserve protection of participants' identities, geographical and demographic data were restricted aside from the level of professional experience and country of origin. These two pieces of information were gathered from responses to the first interview questions and probing questions during the interview. The research study invitation was posted on appropriate Facebook group sites. Interested individuals responding to the invitation represented African countries, the United Kingdom, Australia, and the United States. Upon reading the research invitation, individuals emailed or used messenger to express their interest in participating in the study. These individuals were sent the consent form to their respective email. After reading the consent form and acknowledging they were qualified, the

individual then returned an email with a "I consent" or "I agree." There were two individuals who replied in an email "I consent or Agree" and did not follow up to schedule an interview. Upon receiving the agreement to participate, I inquired as to what time zone the participant was in and created and emailed a Zoom invitation link to the participant.

I provided the participants the opportunity to ask any questions they had regarding the study and the conditions for participation before they consented to the research. Because my admittance to the state prison was denied due to COVID-19 social distancing, participants were recruited from across the world. Inclusion criteria to recruit participants were (a) licensed medical professional and (b) at least 3 years caring for dying inmates while incarcerated. Although no demographic survey questions were asked of the participants other those addressing the inclusion criteria, each recruitment produced some demographic data through conversation. For example, a Walden University student came across my invitation through Facebook and wanted to participate. Not wanting to turn down a medical professional who may not meet experience criteria, I determined that her experience as director of nursing for a 2,000-bed maximum security state prison qualified her to participate. Participant demographics included the following:

- Seven were females and two were males.
- Five were U.S, participants, three were Europeans, and one was Australian.

- All participants were licensed medical professionals who had over 3 years of experience except for one participant who had 2 years of experience. Most participants had over 10 years of experience.
- Titles held by participants included traveling correctional nurse, director of prison hospice, and psychiatric nurse. Three participants specialized in hospice/palliative care, one was a clinical nurse practitioner, and one was a director of nursing working on a PhD.

Data Collection

Using my approved research plan from Walden University's Institutional Review Board, I began participant recruitment on October 24, 2021, and concluded it on December 21, 2021. The participants were recruited through purposeful sampling. Some snowball sampling was conducted because one participant received the research invitation from another participant. Snowball sampling is a technique for increasing the size of a sample by asking one person, the gatekeeper, to propose others for interviewing (Heckathorn, 2011). The research invitation was posted on Facebook along with the Walden University participant pool. Only Facebook postings produced participants.

One individual replied to the invitation via the Walden participant pool but did not volunteer for the study. A Walden University student participated but was recruited from a Facebook group. Another individual contacted me through messenger and requested financial compensation to participate in the study. Overall, there were 31 individuals who contacted me through my Walden University or personal email, and nine individuals proceeded with the interview. There were hundreds of "likes and loves" of the

invitation on the social media sites. One response from the research invitation produced a young lady who wanted to participate. When I inquired about being a medical professional working with dying inmates, her response was "no, I was an inmate for 15 years." There were no major difficulties during the email or messenger communication or getting the consent form sent to the individual and returned before scheduling a Zoom audio-only interview. One participant forgot about the interview but quickly requested a reschedule within the same week.

I used a semistructured interview protocol consisting of 11 interview questions (see Appendix A). Participants were informed they would be contacted if there was any clarification or verification of interview data needed. Only one participant was contacted to ensure a medical term used was correct. Participants were informed at the end of audio recording that the transcript would be sent to them via email for transcript review. Participants were reminded they would be represented in the study only by their pseudonym. To ensure the participants' confidentiality, I recorded only their country represented and their qualifications as a medical professional. Participants were asked if they would like a copy of the study after the research study was published. All responded "yes." One participant reiterated how much she enjoyed being able to participate in the study, noting in her 15-plus years as a nurse in a prison that no one had ever asked her questions like the ones in the interview, and that "they needed to be asked." Statements such as these were examples of why this study was necessary and were a perfect example of the gap in the literature.

I thanked each participant for their comments and involvement at the end of the interview. Each Zoom interview lasted 30–35 minutes, and interviews took place over the course of 2 and a half months. Each participant received a copy of their interview transcript via email after the interview. All participants gave their permission for their transcript to be used in the study. I was able to double-check the accuracy of the participant's responses using transcript review along with several readings that included before and after transcript review and during the analysis process. Participant emails, consent forms, and audio recordings were stored on a private password-protected computer.

Data Analysis

Making a case for the importance of this research study was framed on the concepts of dignity which may or may not be afforded to dying inmates while incarcerated during their EOL journey. Applying the concepts of dignity; respect, autonomy, empowerment, and communication while using a conceptual framework sets the pace and method for the study design and data collection. The goal of this qualitative descriptive phenomenological study was to learn about the lived experiences of incarcerated inmates during their EOL journey. Concepts collected from a conceptual framework may be able to guide a research study and has the propensity for leading to new theories (McGregor, 2018). For this study, medical professionals who care for dying inmates are the lens through which this study explored the concepts of dignity.

Using an interpretative phenomenological analysis (IPA) approach as discussed by Alase (2017) gave me an opportunity to understand the innermost deliberation of the

'lived experiences' of each research participant. IPA is a 'participant-oriented' technique allowing interviewees to express themselves and their 'lived experiences and stories as they see appropriate without fear of misrepresentation. Therefore, utilizing the IPA approach in a qualitative research study reiterates the fact that its main objective and essence are to explore the 'lived experiences' of the research participants and allow them to narrate the research findings through their personal experiences (Alase, 2017).

For this study, I used qualitative semi-structured interviews considered one of the most utilized data collection methods discussed by Evans and Lewis (2018). Analyzing the data allowed me to gain a better grasp of the participants' meanings for their viewpoint, their surroundings, and their lived experiences of the research topic. Data preparation started with a Zoom, audio only, recorded interview. The interview was transcribed by Sonix, an automated transcription software program, immediately. Sonix's participant's transcribed interview was read by the me then emailed to the participant for member checking. The transcribed interview was checked for authenticity by the participant and returned to me typically within 24 hours. If the participant noted in their email edits or suggestions, I read the transcription again ensuring to analyze the edited version. There was also an audio recording of the interview in addition to the textual transcription. The audio transcription allowed for me to hear tones of compassion, distain, happiness, and other emotions associated with responses and conversation.

Saldana (2016) defines coding as "a method through which researchers assign specific values or meaning to their obtained data. Saldana's (2016) descriptive coding method was utilized to assign meaning to the data in this research study. This process

entailed reading the transcripts several times. I then assigned codes representing the concepts of dignity manually. Close attention was paid to note and document any contradictions in experiences from participants as it related to specific interview questions. While all participants expressed loving their jobs and having compassion for their patients, there were no qualities of discrepant cases in this study. The study was designed to interview between eight to ten participants. Data saturation was identified with the ninth participant. The size of the sample is primarily determined by the researcher's evaluation and judgment in gathering the required data to get the crucial findings (McGregor, 2018).

Noted in Chapter 3, Groenewald (2004) recommends two to ten participants or test samples are needed for saturation. For phenomenological research a sample size of nine medical professionals meeting the criteria were chosen to participate in the study. The first two interview questions addressed the inclusion criteria in this study, level of professionalism and length of time caring for dying inmates. Five of the interview questions sought experiences of participants in different directives involving health care for the inmates during their EOL journey. Three of the questions were specific to services offered to EOL inmates in their facility. The last question asked participants to express their experiences as professionals of needed services including palliative or hospice programs that would address dignity in death for EOL inmates.

As a beginner researcher, I determined repeated descriptive coding manually using Microsoft Excel would be more efficient and effective. Using Microsoft Excel provided an organized space to hand code each participant's approved transcription,

enabling me to document relevant responses of each interview question. The first step of finding themes assigned to coding units derived from phrases and quotes directly related to the 11 interview questions. Step two involved line for line coding birthing additional codes. These codes were then merged according to repeated relevance of themes. This process accounted for several more readings of each interview transcript ensuring valuable data was not omitted. Step three consisted of adjoining themes with designated codes eventually leading to patterns forming revealing themselves to be repetitive units. This progression of assigned key codes and descriptive themes developed supporting the answer to the initial research question and two subsequent research questions.

An overriding theme of compassion was paramount from the participants. Compassion and humanity were terms used by all participants in one form or another during their interviews. The ethical aim of palliative care, which is rooted in ideals of dignity, compassion, and the relief of suffering, is naturally at conflict with the prison's logic of punishment, control, and containment.

A climate that is considered hostile to palliative concepts such as autonomy, quality of life, and family bonds, the divergence raises ethical concerns about how and why prison palliative and or hospice care should be provided to dying inmates (Hudson and Wright, 2019). Themes developed from participant responses in this study were vocation, institutional barriers, compassion, and recommendations. These themes were analyzed and organized within the concepts of dignity answering research questions of the study. Concepts of dignity incorporate respect, autonomy, integrity, and empowerment.

Evidence of Trustworthiness

As stated in Chapter 3, trustworthiness is a crucial component to the research study. All participants were asked identical questions and sent a copy of their transcribed interview to edit and/or approve for acceptability to ensure authenticity. Participants were given an introduction at the start of the interview, informing them they could terminate the interview at any point during the session. Participants were advised they could decline answering any of the research questions if desired. Participants were encouraged to express their 'lived-experiences' of caring for dying inmates within their penal facility and share stories without prejudice.

Credibility

I was successful in establishing credibility with the participants by maintaining contact through text and email communication. The ability to interact via email and conduct audio interviews with the participants worked to build desired relationships. I acknowledged valuable importance of the participant taking time to volunteer for this study. Author's Cutcliffe and Mckenna (1999) suggest there is a possibility interviewing participants, the researcher's world of experiences on the subject matter will become increasing like that of the participants. Cutcliffe and Mckenna note this may lessen the risk of the researcher creating their own reality rather than interpreting the reality and lived experiences of the participant. This is how I maintained credibility with the participants of this research study.

Transferability

Evidence of conceptual translation can be used to demonstrate transferability; that is, the same ideas apply more broadly and are demonstrated to be useful in other domains (Suter, 2012). Transferability was determined by going over the transcripts several times and observing (listening) how the participants, while not knowing one another, had similar responses and reactions to the questions. The entire interview of each participant was transcribed fully and researcher responses to include time frames. The transcription depicted word for word, my discussion with each participant. Although no visual recording was conducted during the interviews, protecting participant privacy, I was able to connect with each participant and respect their individual experiences of compassion for dying inmates while incarcerated. Since there was no visual component in this interview process, I was able to concentrate on the participants tone of voice while participants shared their experiences regarding each interview question.

Interested participants contacted me of their own free will and responded in an email “I consent” or “I agree” to participate in the study. Online audio recorded interviews were scheduled at a time and date convenient for the participant. Before interview questions were asked, I assured each participant that they may opt out of the interview or any question at any time. At the end of each interview, the participants were thanked for their time and participation and were reminded of their privacy rights in this study and the processes of destroying all contact information within five years of study publication.

Dependability

To ensure dependability, I maintained the plan I laid forth in Chapter 3 which had my dissertation committee's approval. Noted by (Pezalla et al., 2012) unique researcher traits can impact the gathering of empirical materials in semi-structured qualitative interviews because the researcher is the instrument. Being mindful of this, I was cautious to be consistent asking the interview questions as written on a continuous basis with each participant (see Appendix B). There was one interview in which I overlooked question five in sequence and had to return to that question later in the interview. Listening to the audio recording, reading the transcripts more than three times, and journaling during the interview to capture tones and voices expressions ensured that each participants experiences were documented in this study.

Confirmability

Since I was the instrument of data collection, it was essential to acknowledge transparency at the beginning of each interview with participants on my background in the criminal justice field. The purpose of the study was explained to each participant before interviewing. To accomplish this, I employed bracketing (Fischer, 2009) ensuring my preconceptions, biases, along with preconceived notions while conducting the interviews and data analysis were not injected into the findings and that I preserved an attitude of inquiry and not-knowing. As a scholar, my perspectives on the topic of study have been influenced by years of experience working in the criminal justice system.

Results

The purpose of this qualitative phenomenological study was to explore the experiences through the lens of medical professionals in whether EOL prisoners can die with dignity while incarcerated. The study revolved around exploring the concepts of dignity of respect, autonomy, empowerment, and communication. These concepts were examined from participant responses to 11 interview questions. Considering the value of what individuals say, do, and feel, as well as how they interpret the phenomena under exploration encompasses interpretivism. Assigning meaning to their experiences and interpretivism accounts for this (Nel et al., 2018).

To assure each research study question was answered directly, all participant responses were coded and themed. The technique of systematically categorizing selections from qualitative data in order to identify themes and patterns is known as qualitative coding (Verhülsdonk et al., 2020). This process allowed me to organize data that was unstructured or semi-structured, such as transcripts from in-depth interviews into themes and patterns for analysis.

Because Zoom interviews were only audio recorded, tones and expressions from participants while answering specific questions were journaled. The analysis of data from all participants was conducted from open-ended question responses. Through qualitative coding, the availability to answer the main research question and two subsequent questions were accomplished. Themes emerged from data driven responses to the interview questions.

Vocation

Question #1: Can you explain your level of professionalism in the medical field and how long you have worked in a prison setting along with how you came to work in a prison.

Question #2: Can you explain the process of how you came to work directly with dying inmates?

Excerpts from participants' responses to these two questions reveal their long-standing commitment and job satisfaction. P-b "I absolutely love it. It was it was a blessing in disguise, and it just was a good fit for me." P-d expressed affection for the position as, "And I think that's why I like this job so much is we have our moments of mayhem with the young bucks, right? But I still get my fix for geriatrics if that makes sense."

Two participants expressed their love of their jobs and asked me to excuse them because they started to cry while responding to the interview question. All participants except two have cared for dying inmates for four or more years. Most participants responded they just stumbled into the position and had not necessarily been assigned to dying inmates. P-a responded, "they just kind of stumble into us." One participant acknowledged his reason for working in a prison was because "it happened to be close proximity to my cabin" so, he said he applied for a position there. P-b noted:

> The Warden assigned me to become hospice nurse and quoted 'he called me back and he said, OK, I'm letting you know that you're the new hospice nurse.' And I was like, What? And so, you don't tell the warden over the whole facility no.

Participants expressed job satisfaction which extends itself to the care they provide. Other words used were, “love it, like it, great fit, blessing in disguise, tender-hearted, vulnerable prisoners, elderly inmates, I was hired-that was cool.”

Question #3 Can you explain if there are any types of special housing for dying inmates in your prison/facility and how do inmates qualify for special housing?

Services

All participants acknowledged there was some means to care for the dying whether in house or a community-based hospital or hospice center. Only two participants noted that palliative or hospice services was a program within their facility. P-c stated:

> Yeah. So, all our patients have a choice as to where they want to go so, they can either go to our local hospice or transfer to another prison. We’ve just actually opened. There’s a different prison close by. It’s got a specialist care unit which has a palliative care cell, but they must be a certain age and they must be a sex offender, otherwise they’re not accepted.

P-g explained “palliative care is about two or three rooms that are shared by four inmates to each room and with a hospital bed instead of like regular bunk.” Participants reported most inmates do not want to leave the prison and expressed the staff and fellow inmates with whom they had lived with for years were their family. For instance, P-f stated, “For some people, prison is their home, and that’s a preferred place.” Listed in Table 1 are the specialized palliative or hospice services offered from the facilities of participating individuals.

Table 1

Special Housing for EOL Prisoners

Participant	In-house hospice program	Medical unit/main floor/care center	Residential/ geriatric unit	Community hospital/ hospice program	Transfer to another prison	Remain in cell
b, h, i	√					
a, e, g		√				
d			√			
c, d, f				√		
c					√	
c						√

Although Question #10 is out of numbering sequence, its content aligns with the theme noted in this section.

Question #10: Are there any support programs such as hospice or palliative care for dying inmates at your facility? Discuss these programs and their potential to assist a dying inmate in dying with dignity while incarcerated?

Qualifying factors for special EOL care for incarcerated inmates are typically determined by the institution itself. P-d reported their facilities policy as, “Now, hospice is when we release them if they’re going to die in the next two weeks. We can actually get them special parole and they will go to hospice and die there.” P-g stated, “So I want to say within six months, roughly, I guess it estimated of end of life.” P-i noted:

> The facility looks at several factors that might negate an inmate be moved to special housing. It really depends on level of care that that person needed once

> they had impacts to their ability to do their activities of daily living. Did they need additional medication management? Were their symptoms getting worse and we needed to monitor them more closely? Or were they truly at? You know if someone was truly at end of life.

Question #4: Can you explain the efficiency or lack of health care that is offered and administered to dying inmates during their EOL journey?

People who are dying, in general, need several types of care: medical comfort, mental and emotional attention, spiritual requirements, and functional activities. It is no different for those who will face their EOL journey while incarcerated. Participants overall response to this question acknowledged their facility, within the confounds of mandated security policies, offered care to their dying inmates. Some participants expressed that the care inmates received during their EOL journey were better than those on the outside in the community. P-b stated:

> Well, I can say this, I may be bias about it, the doctors, and the nurse practitioners that we have here they truly are just amazing. I mean, if I was in the dying process, I would love to have some of these professionals taking care of me. We really have some top-notch people that are here. These offenders are offered anything that we have – there care is held to the same standards that you and I have out on the streets and even more.

Regarding the facility, P-a explained:

> No one here has done not resuscitate (DNR), no one has a quoted an EOL journey. Obviously, someone with a terminal diagnosis or progressively

> worsening, we'll manage them on site pain management, mental health services, referrals as needed to community specialists, whether it's pain management, oncology, that sort of thing.

A personal account from P-d self reflects the negative consequences of not being a 24-hour center:

> One of my patients with bowel cancer who's being naughty and isn't allowed in residential at the moment. He's in pain, he's having chemo and he's really unwell, right? And there's nothing we can do for him. Between 9:30 at night and six o'clock in the morning because we don't have nurses on duty. If he feels unwell, he can buzz up to the night duty officers and they can send him to hospital. But that is it. There's no pain relief, there's no monitoring if he's that bad, he needs to go medical.

Participants expressed the available DOL services their facility offered to dying inmates. Some of the responses were very positive, while others offered feelings of frustration, lack of services, lack of privacy for inmates, minimal cooperation of correctional officers, little space to administer health care, and unable to administer proper pain medication.

Institutional Barriers

Questions #5 and #6 allow for the participant as a prison medical professional to reflect on their experiences and opinions of services needed and barriers of those services. Overall, participants noted they had a good working relation with correctional officers who were assigned to the medical units and understood the needs of EOL

inmates as compared to correctional officers on the floors are those who worked 'relief' in medical for another officer.

Question #5: Can you explain any institutional barriers such as administration, funding, and/or correctional officers that may affect your ability to provide support for the dying in your facility?

A systematic review of literature in 2020 identifying barriers and attitudes affecting the knowledge of palliative care by correctional staff was conducted (Macleod et al., 2020). The study concluded only a small amount of academic research is available on the application and practice of EOL training for correctional officers in prisons. Findings in this study support participant responses of institutional barriers in order to provide health care for dying inmates. P-d reported the need for health care in the building:

> We can't even get a podiatrist to come in which affects those inmates with diabetes. we don't get anything. We need Allied Health coming in; we need everything. We had a diversion therapist, but they quit and have not been replaced; we also need nursing assistants.

P-e stated:

> Money being funding for post; I only had a limited number of hours. I could have done so much more from that perspective. Staffing level, so, I think more funding, the more stuff that I think there's always I think you probably will find that most people will say we could with more, we can do more.

P-h stated:

> As a nurse, you're you know, very busy. There's a lot going on. But because somebody is on hospice does not give me more time with that person. I'm still required to do everything that I was supposed to do before, and I feel like often. People on hospice would usually take more of your time, you know, you're slower, you're just hanging out with them or, you know, more communication, more therapy, more therapeutic communication, and you're not afforded that time in the prison setting because you still do have all your tasks.

Other participants reported lack of space being a barrier concern for inmate access of adequate health care. Participants express if cells could have a little bit more space which would enable better equipment to be available supporting the patient. Even something as simple as having a toilet in cells for EOL inmates would enhance health care. Participants spoke of 'administrative barriers' not just correctional, but healthcare as well. P-i expressed "I think administrative constraints definitely impacted some of what we were able to do. And when I say administrative, I mean, administrative from both the correctional side and the medical side." P-e brought up a very interesting point:

> You're taking them away from their essentially their friends and family (inmates). So, it would be really nice to be able to provide some of that input to the prison. But I think it's those barriers around those controlled drugs, really. Almost to have a health care wing with more rooms, more availability, private one to one session, a one-to-one treatment with prisoners.

Question #6: In your opinion, do you feel and if so, what type(s) of services are needed to assist elderly and terminally ill inmates during their EOL care?

P-c offered a different view than the other participants

> I don't think the person actually needs any support. I think it's more support for the people that are left behind, inmates, friends, and families. We don't have any counselling services commissioned in the UK for any prisoners. I think having a palliative care cell within the confines of the health unit would be ideal because most of my men want to stay with their friends.

Recognized concerns in this section suggested the need to address barriers are urgent increase of elderly and terminally ill prisoners; palliative/hospice training with correctional staff, strong clinical and compassionate leadership.

Questions 7,8, and 9 implored a response based on experience from participants revolving around the concepts of dignity which encompasses compassion.

Compassion

Question #7: Can you explain the term dignity and what it means to you for someone going through their EOL journey?

The term dignity involves four key concepts: respect, autonomy, communication, and empowerment., such as P-h thought that autonomy was an attribute to be afforded to a dying inmate "That is a good thing; remain autonomous." P-g said, "dignity would be privacy, your emotions and things like that not being, I guess, broadcast to a room full of people that you may or may not even know." P-f stated, "the biggest thing is to recognize somebody's humanity and actually have that, first and foremost."

Question #8: Can you explain the level of pain management your facility offers to dying inmates?

Concerns about prescription diversion and misuse, offering pain management in prisons is challenging. There seems to be a great divide between medical professionals wanting to dispense appropriate pain medicines verses the penal system security policies. A qualitative study on the constraints of pain management for dying inmates was conducted by a team of authors noting that limitations on prisoner health decisions, care delivery and location, patient advocacy, and care during their EOL journey were significant (Panozzo et al., 2020) which aligned were supported with the data in this study The philosophical clash between prison restrictions and the core principles of palliative care was brought up by the participants. P-a reported most pain meds are controlled substances which are harder to get approved in the prison system in general, much less being able to adjust doses. P-d stated they cannot administer liquids, “We can only give tablets.” P-g offered only the bare minimum is given to those with chronic pain. Facilities who had an organized palliative/hospice program or a system that addresses the needs of EOL journey inmates offer a different perspective of pain management. P-c stated:

> We do exactly the same as what they do in a hospice setting. If I know somebody is coming up to end of life, we will do anticipatory medications for them. We’ll have them all there, ready and waiting for them when they need them. If they don’t particularly want anything, they don’t have to have anything. If they want a buprenorphine patch, we can give them those. We also can give syringe drivers so we can give twenty-four-hour syringe drivers as well if coming up to the end of life, if that’s what they felt that they needed.

P-h reported pain management is offered in their facility, saying, "It varies on the stage that they're at. But there is a significant amount of pain management; oral morphine at least every two hours; it's twenty-four-hour health care."

P-e reports that within the hospice program:

> We have excellent pain management services. If they make it over to the hospital, they get a five-star service really, because we don't have to manage the controlled drugs so robustly, I think some of the regimes in the prison sometimes because of security. Does that detract from the dignity? Maybe. However, it's got to be safe because these things do go on.; the main barriers is around kind of drugs that are administered and administered safely.

Question # 9: In your opinion, how do dying inmates come to terms with dying alone, fearful, and scared while incarcerated?

Participants noted that inmates would disclose feelings of fearfulness when they are alone with a medical professional who sat with them and showed at atmosphere of respect and caring. P-a thought that "men, on average, I feel, tend to not want to show a lot of, and it's not weakness, but I guess in their minds, it's viewed as, you know wanting to cry." P-c answered this question with:

> None of my men have been fearful at all. I think as soon as somebody has a palliative or a terminal diagnosis, I go and sit with them and we have long conversations about what it is, what they're expecting, so we don't hold anything back from them. We're totally transparent in what we think is going to happen. We'll speak about pain relief. We'll talk about the care that we can provide. We'll

> give them all the different options as to what it is they want. Let me say, we'll always reassure them that they'll never be on their own unless that's what they want.

P-f stated, "a lot of guys want to stay in prison because that's their family and friends. Actually, we might be the first people that have actually really shown humanity and love to them for a long time."

One participants' response (who had experience working with hospice patients both in and out of prison) noted the location of death for EOL journey did not seem to be a contributor to an individual's fear. They suggested the feelings of fear, loneliness, and being scared had to do solely with the individual themselves.

Some of the ideas expressed by participants in this section was a lack of suffering, humanity, pain management, compassionate visits, caring for the inmate, showing the patient validity, ensuring the patient's wishes after death come to fruition, and patient comfort.

The final question asked participants to express their recommendations for improving palliative care for dying inmates within their facility.

Recommendations

Question #11: As an experienced medical professional working with dying inmates, what suggestions do you have for improving palliative and EOL care in prisons for the future?

A recently conducted study offered prisoners with palliative and EOL care needs included building relationships with communities both outside of prison as well as staff

and administration inside a prison is critical (McParland & Johnston, 2019). To ensure improved treatment for prisoners with progressive and life-limiting illnesses, clarity of correctional service processes, protocols, and aspects of security, as well as relevant training for health professional is required.

This sentiment is duplicated by the participants in my study. A noted quote from P-i explains the level of dignity their facility and pertinent staff offer inmates during their EOL journey.

> To improve it would be to have more access to wellbeing services and the kind of softer skills. More psychological interventions, the wellbeing interventions, the spiritual interventions, all the things that make a hospice. It would be really nice if we could infiltrate the prisons a little bit more or even team up with the provision that's already on board.

P-f stated:

> I think there needs to be conversation and education for prison officers within these establishments; having this culture to be able to recognize when people with complex needs attributed frailty and as they come in towards the end of their life; exclusive outcomes; it goes back to that how we treat our most vulnerable these inmates – they still have families and loved ones on the outside. Actually, as a society, we're demonstrating that we don't care, and we don't value for their family members."

Suggested needs expressed by participants included: separate space, whole team approach, palliative care training for correctional officers, inmates' access to well-being services, medical professionals' ability to have resources necessary for EOL inmates.

I was able to guide the participants to speak openly on their experiences, concerns, and suggestions of health care provision for EOL journey prisoners due to the focus of the questions. Replies to interview questions and stories documented reflected each participant's own point of view. Theming and coding participant stories based on their connectiveness, and consistency assisted me in narrative analysis (Clandinin & Connelly, 2004). Reviewing research questions and participant replies, the responses were addressed whether EOL journey inmates are afforded the ability to die with dignity.

I kept track of how themes related to the RQ, SQ1, and SQ2 and of my study throughout the data analysis (see Table 2). All the themes in this study were supported with the main RQ, but when it came to assessing how they related to the sub-questions, they differed. Each theme aligned to a certain sub-question.

Table 2

Theme Association to RQ and Sub Questions

RQ: How do medical professionals describe their experiences regarding dignity in the EOL journey of inmates?

SQ1: According to the medical professionals how might the penal system employ factions supporting dying with dignity for EOL journey inmates?

SQ2: According to medical professionals how do life-sentenced inmates come to terms with feelings of loneliness and fear during their EOL journey?

Themes	Associated Sub Question
Compassion, Institutional Barriers Service, and Recommendations	SQ1
Vocation, Compassion, and Service	SQ2

Summary

In summary, discussion was conducted on the recruitment of participants and data collection processes, including how each participant confidentially were protected, how each person was communicated with, consent to participate, and transcript approvals from each participant. The data was gathered through semi-structured audio-recorded interviews with nine participants. All participants met the inclusion criterion of prison medical professionals at least three years except for one participant who was identified earlier. While demographics of participants was not formally requested to protect their identity, I did identify demographics in its lowest form based on conversation of represented countries, gender, along with the professional title of participant.

Codes and themes were recognized from data driven responses of each participant of the 11 interview questions. The main theme noted throughout the data that umbrellaed participants experience was compassion. This was in accordance with Clandinin and

Connelly (2004) narrative data analysis. Themes identified in this study were vocation, services, institutional barriers, compassion, and recommendations. These themes were pertinent in answering the RQ and two sub RQ's.

Themes of institutional barriers, compassion, and recommendations will assist with answering the two subsequent research questions, RQsub1: How might the penal system employ factions supporting dying with dignity for EOL journey inmates and, RQsub2: Do life-sentenced inmates come to terms with feelings of loneliness and fear during their EOL journey? Chapter 5 will include interpretation of findings, limitations of the study, recommendations for future research, implications of positive social impact, and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative IPA study was to explore prison medical professionals' perceptions of inmates' personal experiences in dying with dignity. Because there was little research on the concepts of dignity and its application in a prison setting, this study was important. To guide my research, I used the following RQ and sub questions.

RQ: How do medical professionals describe their experiences regarding dignity in the end-of-life journey of inmates?

RQsub1: How might the penal system employ factions supporting dying with dignity for end-of-life journey inmates?

RQsub2: How do life-sentenced inmates come to terms with feelings of loneliness and fear during their end-of-life journey?

In Chapter 5, I discuss the concepts of dignity applicable to EOL prisoners through the lens of prison medical professionals. The findings are discussed in relation to the reviewed literature in Chapter 2. I also include interpretations of findings, limitations of the study, recommendations, implications, and a conclusion.

Five themes emerged through data analysis in this study: (a) vocation (participants overwhelming love of their jobs), (b) services (participants expressed the lack of services to administer proper health care to end-of-life prisoners), (c) institutional barriers (participants noted prison and medical barriers associated with their ability to manage appropriate health care to their patients), (d) compassion (participants presented the impression of awe-inspiring compassion toward their patients' needs during their end-

of-life journey), and (e) recommendations (participants offered an array of recommendations needed for end-of-life prisoners to die with dignity while incarcerated). These themes revealed prison medical professionals' perspectives regarding the opportunity of EOL prisoners to die with dignity while incarcerated, which was supported by the literature.

EOL care for prisoners is not a new concept, yet it is an urgent one needing immediate attention. Due to chronic illnesses among the aging prison population, the largest cohort of prisoners, proper implementation of EOL care is of significant concern for prison administrations. More and more individuals are facing their EOL journey while incarcerated (Steely Smith et al., 2021). This study's qualitative IPA technique allowed me to explore the perceptions of prison medical professionals regarding EOL experiences of prisoners. The findings may inform future policy and procedures affecting sentencing reform related to end-of-life prisoners.

Interpretation of Findings

Nine one-on-one Zoom audio-recorded interviews, reflective journal notes, the literature reviewed in Chapter 2, and the conceptual framework emphasizing the importance of autonomy, integrity, empowerment, and respect as defining characteristics of dignity in the end-of-life journey for older and terminally sick inmates (see Kadivar et al., 2018) were used to analyze the findings of this IPA study. This led to the clarification and confirmation of information regarding prison medical professionals' perceptions of dignity in death for inmates while incarcerated. A compelling sense of compassion was expressed by participants throughout data analysis. Prison nurses have an opportunity to

be change agents. Difficulties such as professional and social indifference toward incarcerated prisoners can intensify feelings of fear, loneliness, and mistrust among end-of-life prisoners (Petreca, 2021). Passion and job satisfaction mentioned by participants in this study were vital to their career as prison medical professionals even though there were several obstacles and pressures associated with administering health care in prison. Major obstacles participants expressed involved lack of services and institutional barriers in administering health care. Prison environments are controlled and compliant atmospheres that often negate the concept of compassion. For prison medical professionals to provide compassionate care, they need to set aside preconceptions and prejudices of inmates' offenses while remaining attentive; humanity is required (Lehrer, 2021).

Three of the nine participants expressed satisfaction with their facility's operational processes in caring for end-of-life prisoners. Of these three, one noted their facility housed an organized hospice program, while the other two noted their facilities offered health care services for end-of-life patients, but not officially as an organized palliative or hospice program. Although most participants reported their facility offered some means of end-of-life care for their patients, one participant noted their facility did not have the means or ability to provide even minimal health care services.

Five themes emerged from analysis of the data collected from semistructured interviews with prison medical professionals: vocation, services, institutional barriers, compassion, and recommendations. The findings suggested that medical professionals who choose to provide health care services within the confines of a prison setting have an

overwhelming sense of compassion for their patients. Participants acknowledged institutional barriers that prohibited them from administering what they considered proper health care to end-of-life prisoners. This finding was mostly associated with institutions that did not formally recognize the need for palliative or hospice services in their facility.

The purpose of this study was to discover from medical professionals what is considered necessary to support inmates' death with dignity. Collecting data is pertinent in a study, but equally important is searching for answers to unanswered questions. McGregor (2018) noted that the procedures or guidelines researchers use in a study, as well as the principles, theories, and ideals that underpin them, are referred to as the research methodology. The main research question was the foundation for this study: How do medical professionals describe their experiences regarding dignity in the end-of-life journey of inmates?

All the medical professionals in the study acknowledged their work with dying inmates as fulfilling. Depending on the specific facility, participants noted contradictions in their experiences as to the level of dignity a prisoner could experience during their end-of-life journey. The findings indicated that if a facility offered an organized palliative or hospice program along with compassioned medical professionals, dying with dignity was afforded. In facilities that did not offer an organized program but rather confined its health care based on prison security policies, minimal provisions were afforded to ensure dignity in death.

These findings are consistent with previous research conducted by Neubauer (2019) study who explained the term dignity is very subjective and the concept of dignity

in death is poorly defined. Findings indicated that correctional officers assigned to medical units containing older or terminally ill inmates were more likely to assist health care providers in treating dying inmates than those who had not been exposed to this population. The first sub question addressed in the current study was the following: How might the penal system employ factions supporting dying with dignity for end-of-life journey inmates? Most participants noted the application of pain management, while some indicated privacy for dying inmates was needed along with more medical staff to devote to dying inmates. The opportunity for EOL prisoners to be released to die with family or friends was expressed by most participants, even those who operated an organized palliative or hospice program.

Studies reviewed in Chapter 2 addressed older or terminally ill inmates who had applied for compassionate or medical release only to die in prison before approval. Holland et al. (2020) found that it is more humanitarian for end-of-life prisoners to remain incarcerated than releasing them into the community because they may not be able to obtain medical treatment for their illness. The second sub question was the following: How do life-sentenced inmates come to terms with feelings of loneliness and fear during their end-of-life journey?

Findings revealed within an atmosphere of respect and compassion offered by those administering health care services, prisoners were able to process their fears during their end-of-life journey. Participants noted some prisoners would prefer to die while incarcerated with their prison family and friends as opposed to outside. Findings also

indicated that improving communication between health care providers and prisoners about their health conditions and EOL processes would decrease feelings of fear.

Chronically ill inmates should have an opportunity to be involved with health planning and decision-making resources to promote their health and facilitate a good death (Loeb et al., 2014). Palliative care and hospice care seem to be thought of interchangeably, but there are some differences. Palliative care is medical treatment associated with patients' symptoms as well as treatment to cure their illness (Villines, 2021). Palliative care is intended to complement a person's existing treatment by focusing on their quality of life. An individual with a terminal illness who is nearing their end of life is the focus of hospice care (Villines, 2021).

Limitations of the Study

One limitation of this study was COVID-19 social distancing mandates preventing face-to-face participant recruitment and data collection. Adhering to government pandemic mandates, I shifted participant recruitment from medical professionals within a specific prison to participants around the world through Facebook. Posting my research invitation on Facebook groups such as Prison Nursing and Traveling Correctional Nurses produced a diverse geographical group of participant responses.

When a small sample of great diversity is chosen, data collection and analysis will produce two types of results: (a) high-quality, detailed descriptions of each experience, which are useful for documenting uniqueness, and (b) important shared patterns that cut across experiences and derive their significance from having emerged from diverseness. The COVID-19 Bureau of Prisons visitation mandate changed the process of data

collection from face-to-face interviews to audio-recorded Zoom interviews. A disadvantage of audio-only recording was my inability to note facial and body expressions of the participants. Provisions were made to note the tone of a participant's response.

I had personal experience working in correctional institutions, but not with end-of-life prisoners. I mitigated researcher bias by putting my prejudices aside and concentrating on the data gathered through one-on-one interviews. Because of the small sample size and qualitative nature of this study, generalizability of findings is limited. Findings cannot be generalized beyond the prison medical professionals who participated in this study.

Recommendations

The findings of this research study offered insight into important components aiding prisoners to experience dignity during their EOL journey while incarcerated. The emergent theme was medical professional's sense of compassion. The study showed that a large portion of institutionalized dying patients being able to experience dignity in death could be achieved through the compassion shown them by prison medical professionals. This was reiterated in the quoted stories from participants whereby prisoners processing through their EOL expressed a desire to stay in the prison and not be released. Identifiable topics for future research were discovered through the process of this study.

Further research is recommended by the establishment of jurisdictionally specific best practice treatment techniques based on palliative care principles noting a significant

need to enhance the provision of evidence-based, person-centered palliative care in prisons.

I recommend further research on provisions and training staff of palliative care in prisons which is currently complicated by several structural and organizational barriers, restricting inmates access to health care.

I recommend considering the cost of housing dying inmates which is at minimum, double the expense for states and taxpayers, precluding chronic health care cost associated with the individual. Calculating the possible cost savings to the federal government of incarcerating fewer elderly and terminally ill prisoners, could be in the range of $30,000 per person (Ferraro, 2021).

This research offers a look at how medical professionals expressed their lives as health care providers working in a prison and how they perceived their ability to offer health care to EOL journey inmates. Future longitudinal study might help to extend the existing viewpoint by providing a real-time view of everyday dynamics and how effective concepts of dignity are afforded to EOL health care within the confines of prison security policies.

Reiterating that a nations character is measured by how it treats it most vulnerable citizens (Atkins, 2020) suggest further research is necessary to include a blended approach from medical professionals, facility administrations, and correctional officers on identification of inmate EOL health care needs.

Implications

Findings in this study may support the need for correctional systems to be built on the foundation of human dignity. This concept acknowledges each person's inherent value and ability to exercise self-control, autonomy, and communication be incorporated into their EOL journey while incarcerated. This may lead the Bureau of Prisons revising current state to state importation of EOL health care applicability to a mandated federally controlled EOL health care system. Providing and advocating for in-prison palliative care is intrinsically associated with addressing the general societal consequences of incarceration, such as inadequate palliative care and the dehumanize effect of incarceration. Further positive social change from the findings of this study may support clearer and more precise policies of compassionate or medical release with elderly or terminally ill inmates.

Prison medical professionals have a moral commitment to speak out about the significance of compassion, dignity, and safety for all people, particularly those who are marginalized and vulnerable. Supporting social justice helps to look after the health and well-being of those we have the honor of serving (Kheirbek, 2021). Supporting this study's findings, prisons which incorporate palliative and hospice care programs report potential for improving EOL care to dying inmates (Coyle, n.d.).

Conclusion

The purpose of this qualitative phenomenological research study was to explore possibilities of elderly and terminally ill inmates during their EOL journey to die with dignity. This experience was explored through the lens of prison medical professionals

caring for EOL prisoners. The concepts of dignity: respect, autonomy, empowerment, and communication framed the foundation of this study.

Nine participants were interviewed, and reflective notes were gathered on their experiences of an EOL inmates' ability to die with dignity. Participants represented penal facilities within the United States, UK, and Australia. Participants were open and honest about their experiences with administering health care services to EOL inmates within a prison setting. The themes of having compassion for their patients, vocation, why they went into prison nursing- the love of their careers, what services are needed to effectively administer health care to EOL incarcerated patients, learning to work around institutional barriers which limit service application, and recommendations based on experience on what is needed to provide EOL inmates for appropriate health care emerged as the results in this research study.

In conclusion, this research study sought to look through the lens of prison medical professionals on the availability of EOL journey incarcerated inmates having the ability to die with dignity. Despite the limited sample size, findings provided experiences from hands-on medical professionals that are critical for EOL inmates ability to die with dignity while incarcerated.

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Appendix A: Interview Questions

1. Can you explain your level of professionalism in the medical field and how long you have worked in a prison setting along with how you came to work in a prison?

2. Can you explain the processes of how you came to work directly with dying inmates?

3. Can you explain if there are any types of special housing for dying inmates in your prison/facility and how do inmates qualify for special housing?

4. Can you explain the efficiency or lack of health care that is offered and administered to dying inmates during their end-of-life journey?

5. Can you explain any institutional barriers such as administration, funding, and/or correctional officers that may affect your ability to provide support for the dying in your facility?

6. In your opinion, do you feel and if so, what type(s) of services are needed to assist elderly and terminally ill inmates during their end-of-life care?

7. Can you explain the term dignity and what it means to you for someone going through their end-of-life journey?

8. Can you explain the level of pain management your facility offers to dying inmates?

9. In your opinion, how do dying inmates come to terms with dying alone, fearful, and scared while incarcerated?

10. Are there any support programs such as hospice or palliative care for dying inmates at your facility? Discuss these programs and their potential to assist a dying inmate in dying with dignity while incarcerated?

11. As an experienced medical professional working with dying inmates, what suggestions do you have for improving palliative and end-of-life care in prisons for the future?

Appendix B: Recruit Participant Flyer

Would you like to take part in a research study about life sentenced inmates' ability to die with dignity while incarcerated?

Studies show there is little research addressing the end-of-life journey for dying and elderly inmates.

Your participation in this study may assist with penal policy and legislative changes for those who are dying and pose no safety risk to the public.

To participate in this study, you must be an MSN, RN, or LPN (licensed) with at least three years working experience with dying inmates in a penal facility.

If interested in participating in this study, please contact:

Charlene Lupo