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Contextualising Professional Ethics: The Impact of the Prison Context on the Practices and Norms of Health Care Practitioners

White K, Jordens C, Kerridge I. (2014)

Abstract

Health care is provided in many contexts—not just hospitals, clinics, and community health settings. Different institutional settings may significantly influence the design and delivery of health care and the ethical obligations and practices of health care practitioners working within them. This is particularly true in institutions that are established to constrain freedom, ensure security and authority, and restrict movement and choice. We describe the results of a qualitative study of the experiences of doctors and nurses working within two women’s prisons in the state of New South Wales (NSW), Australia. Their accounts make clear how the provision and ethics of health care may be compromised by the physical design of the prison, the institutional policies and practices restricting movement of prisoners and practitioners, the focus on maintaining control and security, and the very purpose of the prison and prison system itself. The results of this study make clear the impact that context has on professional practice and illustrate the importance of sociology and anthropology to bioethics and to the development of a more nuanced account of professional ethics.

Keywords

Prisoners, Health care, Human rights, Professional practice, Professional ethics, Nursing ethics

Introduction

Health care practitioners provide care in a variety of contexts, including public and private clinics, the home, and the battlefield and in a variety of institutional contexts such as schools and universities, workplaces, and community centres. In some institutional contexts the professional and ethical obligations of health care practitioners may be challenged or compromised. This will be particularly the case in institutional contexts that have significant deprivation of individuals’ liberty as their *raison d’être*. In this they differ from other, more usual contexts, such as the hospital. Patients in hospitals allow themselves to be confined in order to enable carers to achieve the goals of these institutions, that is, therapeutic benefit. In contrast, health care practitioners who work in prisons see patients or clients whose liberty is severely restricted; and they see them in a context that is structured precisely to give sustained expression to this lack of liberty. A range of policies, procedures, and methods are implemented to secure prisoners and protect society. These include: physical barriers such as the use of perimeter walls and control of entry and exit points;

organisational policies, including the security classification of prisoners, and politically driven policies such as “getting tough on crime” through legislation. Organisational and political practices and policies, both formal and informal, also impact on the delivery of health care to prisoners and on health care practitioners charged with caring for incarcerated patients (Weiskopf 2005). This lack of liberty, which characterises correctional contexts, inevitably impacts on patients, the delivery of health care, and on health care practitioners.

The Prison Context

Sociologists and anthropologists have long recognised that social contexts, such as institutions, may define and control the behaviour of people and communities. “Institution” is a complex concept, however, with many different meanings, including: “an organisation or establishment founded for a specific purpose,” the “building where such an organisation is situated,” and “an established custom, law, or a relationship in a society or community” (Hanks 1979, 757). An institution, therefore, denotes a physical site—buildings, walls, and barbed wire—as well as the organisation that controls and manages the site. This will include the function and purpose of the organisation, its administrative practices and goals, and staff. (Organisation in this sense refers to a formal arrangement whereby those “on site” work to a common goal.) We also speak of institutions in a different sense when we speak of, for example, the institution of marriage. In this sense “institution” means social, cultural, and legal arrangements that make up the fabric of society and provide important social and cultural norms, which are enforced by law. Prisons, as institutions, therefore, are buildings, organisations, and structures that shape and determine behaviour by means of formal rules and customs.

Prisons, however, may differ from other institutions to the extent that they control all aspects of life. The sociologist Erving Goffman (1961) has characterised prisons as “total institutions.” The key characteristic of total institutions is their “encompassingness”—that is, the degree to which they break down the barriers dividing the usual spheres of life, such as sleep, play, and work, and the degree to which they are incompatible with key aspects of modern life, including work and family life (Goffman 1961). Total institutions strip away (or “mortify”) a person’s identity by institutional practices that include the radical loss of freedom, removal from one’s social network, limiting or removing personal possessions, an inability to maintain any privacy, and the loss of a sense of personal safety.

The inmate’s self is also violated in physical ways—“the boundary that the individual places between his being and the environment is invaded and the embodiments of self profaned” (Goffman 1961, 23). Prisoners are never alone and always watched. Private and potentially embarrassing information about themselves is available to the prison staff. They can be subjected to strip searches and medical examinations, and they have little choice over their food, their accommodation, cell or dormitory partners, and where they are imprisoned. This lack of agency and physical threat add to the process of mortification.

Goffman outlines three other important features of total institutions. Firstly, he describes how institutional perspectives shape and form inmates’ identities in ways that involve a particular type of moral determinism.

Inmates must be caused to *self-direct* themselves in a manageable way, and, for this to be promoted, both desired and undesired conduct must be defined as springing from the personal will and character of the individual inmate himself, and defined as something he can himself do something about (1961, 87, emphasis original).

Second, Goffman also describes how professionals are generally brought in to provide technical services related to one of the principal aims of the total institution, which is the human treatment of those within its “walls.” He notes, however, on the basis of his own empirical research, that these professionals feel dissatisfied with their work in total institutions due to “feeling that they cannot

here properly practise their calling ... [and are in] a somewhat difficult relation to the official goals of the establishment" (1961, 92).

Finally, Goffman points to the rigidity and impermeability of total institutions, that is, the degree to which social standards inside such institutions differ from those outside them and constrain both the way the prison population and the professionals who work within the institution behave and the ways in which the institution is organised or can be reformed.

International associations such as the United Nations (1955), international professional bodies including the International Council of Nurses (ICN) (2011) and British Medical Association (BMA) (2001), and national professional associations including the Australian Medical Association (AMA) (2013) recognise the problems inherent in providing health care to prisoners and the role of health care practitioners working in the prison context. All have published ethical guidelines to assert the rights of prisoners to health care and to outline health care practitioners' ethical obligations with respect to prisoners. Little is known, however, about how these guidelines or codes are enacted, nor if they adequately articulate the experience of clinicians working in prisons.

For the most part, discussions of health care in prisons have focused on the health status of prisoners and on specific issues regarding their care, including the prevention and management of infectious diseases (Butler et al. 1997), mental health problems (Tye and Mullen 2006), research (Arboleda-Flórez 1991), and women's health (Lewis 2006). Where ethical and professional issues have been explicitly raised, these discussions have, in the main, centred on major historical events or political controversies, such as the role of doctors in Nazi Germany (Vollmann and Winau 1996; Shuster 1998; Katz 1996; Lefor 2005), in American military prisons, notably Guantanamo Bay and Abu Ghraib (Clark 2006; Iacopino and Xenakis 2011), and in the procurement of solid organs for transplantation from prisoners in China (Lin et al. 2012). Most other academic explorations of the ethical issues raised by the provision of health care in prison settings have tended to concentrate on the obligations owed by forensic medical specialists and psychiatrists (and, to a much lesser extent, nurses) and have tended to be theoretical, rather than empirical, addressing issues such as dual loyalty (O'Brien 1998), reports for third parties (Taborda and Arboleda-Flórez 1999), body cavity searches (Anno and Spencer 1998), state-sanctioned killing (Marks 2005), social equity (Birmingham, Wilson, and Adshead 2006), autonomy and consent (Roberts 2002), competence (Taylor and Buchanan 1998), confidentiality (Fletcher et al. 1998), and justice (Weinstein 2002).

A small number of empirical studies have explored the experience of nurses working in correctional facilities. While these have generally not focused on the ethical concerns faced by nurses, they have served to identify many issues that have ethical implications, including: dealing with risk and violence (Crampton 2007; Maeve 1997), professionalism (Weiskopf 2005), stress and burnout (Happell, Pinikahana, and Martin 2003), job satisfaction (Flanagan 2006), the tension between health and custodial concerns (Veal 2001), the challenge of dealing with dual loyalties (Holmes, Perron, and Michaud 2007), consent for medical care (Hayes 2006), involvement of nurses in state-sanctioned killing (Holmes and Federman 2003; Hooten and Shipman 2013), professional isolation and marginalisation (Holmwood and Rae 2003; Doyle 1998), and gender issues (Sered and Norton-Hawk 2008).

In this paper we report the results of a qualitative study of the experiences of doctors and nurses providing care to women in maximum- and minimum-security correctional centres in New South Wales, Australia. The aim of this study was to ascertain: (1) whether the prison context presents different moral problems or challenges for health care workers from those they might experience in other professional contexts, and (2) if there are different moral problems and challenges, whether these compromise the ethical aspects of health care practice or merely complicate it.

Participants and Methods

As the purpose of this study was to examine the impact of the prison context on the health professionals working within it, we chose a qualitative approach as “it studies people in their natural setting” (Pope and Mays 2006, 4). We employed semi-structured interviews and field observation.

Selection of Study Sites

The study was conducted in the two women’s prisons in New South Wales, Australia. This enabled us to explore the impact of maximum, medium, and minimum levels of security on prison health care practice and practitioner–patient relationships. The two women’s prisons included all three security classifications. The two facilities held a total of 353 inmates. The study was restricted to doctors and nurses.

The Study Population

The participants in this research included medical practitioners and registered nurses employed by Justice Health NSW working in these prisons. Practitioners employed in these facilities included those with expertise in psychiatry and mental health, public health, general practice, women’s health, and indigenous health.

Sampling

Interviews were conducted with medical practitioners and registered nurses at each site until thematic saturation was reached (the point at which no new data emerged). The sample was guided by two considerations. The first was to ensure an adequate pool of accounts from which to gain enough data to enable us to form some general conclusions. The second was to account for the impact that professional differences might have on ethical dilemmas by having practitioners in each professional stratum at each correctional centre.

We interviewed seven nurses and six doctors for this study. The gender, age, and speciality of the clinician participants is withheld for reasons of confidentiality.

The interviews were conducted on site with all but two participants who elected to be interviewed outside the workplace. The interviews lasted one to one and a half hours. The interview questions included structured and semi-structured questions. Structured questions included demographic information and permission to audio-record the interviews. All participants were asked about when they learned about ethical practice in their health profession and what ethical principles arose in the context of their practice. Participants were then asked to reflect on two different events of ethical significance related to their work context: one that was resolved to their satisfaction and one that was not. Participants were asked specific questions about the two events; for example, who was involved, why it was an ethical issue for them, whether they would do anything differently if the same or similar event occurred, and what they learned from the experience. Participants also were asked more generally whether they considered that the prison context gave rise to specific ethical concerns.

Data Collection and Analysis

Interviews were audio-recorded and transcribed for analysis. Identifying names were coded according to occupation, the security classification of the correctional centre, and interview number: for example, nurse, maximum security, interview 1.

The data were thematically coded using NVivo7. The data were read for anticipated and emergent themes. When new themes were discovered, previously read transcripts were re-read for the new themes (Rice and Ezzy 1999). After all the data were coded, related themes were grouped together under increasingly abstract, major themes (Attride-Stirling 2001).

Ethics Approval

Ethical approval was required for this study and both The University of Sydney Human Research Ethics Committee and The Corrections Health Service Human Research Ethics Committee approved the research. All participants gave their informed consent prior to their participation.

Results

Physical Context

Prisons are built specifically to contain, isolate, and observe those members of society requiring “correction”: They are, therefore, characterised by “secure perimeters and the technology of surveillance and containment: omnipresent reminders of the restrictive and custodial nature of prison life” (Doyle 2003, 308). Unsurprisingly, these physical characteristics define not only what prisoners can do, where they live, and how they can move, but also how and where they receive health care.

Disciplinary Spaces

The various and distinct disciplinary spaces—the compound, the areas bounded by fences—and places—the cells, houses, pods, cages, and so on—consistently featured in the descriptions that participants gave of the provision of health care to inmates. These disciplinary spaces and places were frequently described using military references: Patients saw nurses at the “sick parade,” received their prescribed methadone at the “methadone parade,” and were required to attend “muster.”

Nurse 3, Maximum Security: [T]hey [women on remand] wait in the cage.

Nurse 1, Minimum Security: [Y]ou see them [inmates] at the sick parade.

Movement

Prisoners are always being moved between different parts of the prison, from their sleeping quarters to work, or to the clinic, and sometimes out of the prison to hospital or to specialist appointments. This was an issue for health care professionals because movement in correctional centres, both of prisoners and of health care staff, is highly regulated and monitored. Sick parades, methadone clinics, and medical appointments—all were tightly supervised and constrained, both by the need to maintain order and security and by the availability of correctional officers (who were ultimately responsible for the movement of prisoners). While moving prisoners significantly impacted on the provision of health care, so too did limitations or prohibitions upon the movement of prisoners. During “lock-downs,” for example, prisoners were unable to move around the prison and were not able to attend clinic appointments or seek assistance from health care staff. This was clearly an issue for the participants in our study. But the restriction of movement and activity that occurred simply as a result of overcrowding, of having too many prisoners in one place, was also a major concern for health care staff—too many prisoners congregating around the pill window; too many prisoners dawdling at sick parade; or too many prisoners intimidating or abusing the nursing staff. This often made health care delivery impossible, particularly where correctional officers did not act to control and disperse the group as it was not seen to pose a security risk.

Security, Discipline, and Order

Concern about personal security was evident in the data, with all study participants raising this issue. For these participants security concerns were an ever-present feature of their practice—interfering with the delivery and provision of health care to inmates and compromising access to health care both within and without the correctional complex.

Nurse 4, Minimum Security: We have quite a number of girls who escape and security seems to be extremely lax.

The perceived risks associated with the unpredictability of patients created particular security concerns for the participants in this study. In most health care settings, relationships between professionals and patients are grounded in mutual respect and trust. In the correctional context, however, it was generally accepted that trusting that your patients would consistently be well disposed towards you was foolish, at best, and dangerous, at worst.

Nurse 1, Minimum Security: Yes, there are, I mean, when I have been in the clinic with more than one inmate or I've had to walk from one place to another without an officer and there are inmates around, I don't like that, 'cause you never know who they are, what they've done, what crimes they've committed, you don't know if they could just snap, and I just feel unsafe (emphasis added).

Discipline and control were thus central to dealing with unpredictable and potentially violent inmates. The nurses at the minimum-security correctional centre maintained that since security was the primary role of the correctional officers then they ought to be the ones to control the inmates. Health practitioners needed to be able to do their job—delivering health care to those who were imprisoned—and this was only possible where they were not threatened, which required that correctional officers enforced discipline and maintained authority.

Nurse 4, Minimum Security: I think they need more discipline though, that's my view, I've seen the inmates swear and carry on at the guards and us and it's like they get away with it. I think there needs to be more discipline, but they do have it good. I think their rights have improved a lot which is good and I think they do get a lot of respect compared to years ago and there has been less abuse from the officers and especially like less physical abuse too ... but I think they [correctional officers] need to be more of an authority figure (emphasis added).

The nurses at both institutions, however, described how they were also responsible for security and maintaining order in quite practical ways. For example, the nurses were the ones responsible for keeping the keys to the drug cupboard safe and secure, as is the case in most hospitals and health care clinics. But in contrast to these usual health care settings, clinicians working in the correctional context have to be more mindful of security, including both the security measures required for the detention of prisoners and their own personal security. Personal security concerns included being careful about the conditions under which patients may enter the clinic/hospital. Patients must not, for example, be given the keys to the clinic and can only enter the clinic accompanied by a correctional officer. A number of the health care professionals interviewed described how some override the policy and allow unaccompanied patients into the clinic on the basis of their own clinical assessment and their knowledge of the patient's criminal record. But knowing the (patient's) crime may itself be a problem.

Nurse 1, Minimum Security: We are not really supposed to bring any inmates into the clinic unless they are accompanied by an officer, but there are occasions when I will. But these are the clients where I know that their history, their crime history, is, basically, non-violent crimes, or fraud, or something like that. I bring those in. So I am a bit selective on who I allow in on my own. But we're really not supposed to.

In other words, the participants in this study described how they used both their clinical and moral judgement in assessing the security risk posed by inmates and how at times their professional duties overrode any concerns they had about their own security, whereas at other times their personal security concerns overrode their professional obligations.

Nurse 2, Maximum Security: [Some of] the women I've had to deal with were quite high security risks, murderers and criminals of the worst order, and in fact I would go so far as to say, and this sounds like I am judgemental, but believe me, and I suppose I have maturity on

my side and don't say it lightly, that I would go so far as to say that in one particular case the person was simply evil, and I wasn't prepared to compromise my life or my security for the sake of confidentiality (emphasis added).

Security concerns were explicitly or implicitly evident in all aspects of the provision of health care in prisons, particularly the security classification of prisoners, which mandated which correctional facility prisoners were allocated to, whether they could have day release to work in the outside community, and whether they were eligible to have their children with them. The security classification of prisoners was therefore critically important for health care practitioners, particularly for those concerned with antenatal care.

Doctor 2, Maximum Security: When prisoners are sentenced they [prisoners] are given a security classification ... depending on what their risk of escape would be. ... This is important for me because I do antenatal care for women—so if they are un-sentenced when they deliver, it means that they remain at [the maximum security centre] and there are no facilities for mothers and babies to be resident.

Whether health care practitioners ought to know the reason why their patients were incarcerated and the security classification they were given was an ethical issue for many of those interviewed. For some of the participants, health care professionals should “know the crime” principally because this knowledge would allow them to minimise the risks to their personal security. This was felt to be particularly true when dealing with very violent patients and those with a history of, for example, hostage taking. But this was also felt to be true because it would enable health care practitioners to “bend the rules” for prisoners whose imprisonment was for white-collar crime—who did not constitute a threat to their personal security and safety and who perhaps belonged to a similar “class.”

Importantly, a number of practitioners described how even where they had little interest in knowing the crime, they found out about it anyway. This was a cogent reminder that privacy neither existed in the prison context nor was expected.

Doctor 1, Maximum Security: I think it's possible to know [the crime] without asking. An inmate will usually volunteer what she's done, and why she's here and that she didn't do it.

This created a significant ethical concern for a number of the doctors and nurses interviewed, as they felt that in order to provide non-judgemental and non-discriminatory care, and to treat all patients fairly, they should be ignorant of their patient's crime.

Nurse 1, Minimum Security: Of paramount importance to me is that you treat the girls all the same as you would people in the community—with respect, I mean. I have no idea what they have done to be brought into the [prison] system. I just treat them as I would anyone else, fairly, all the same, you know, not showing any favouritism or discrimination towards them.

Protection of Other Patients

Security was also construed by participants in terms of a (moral) requirement to protect others. This was most evident in policies that required health care practitioners to report assaults on prisoners. However, protecting prisoners from other prisoners was not always straightforward. One participant described a situation where a prisoner experiencing seizures was moved into shared minimum-security accommodation to assist in the management of her condition.

Nurse 1, Minimum Security: This girl presented saying, “I have been having fits,” [non-witnessed fits], and for her safety the girls [other nurses] contacted the doctor over the weekend because they were concerned that she might have a fit and would be injured. The doctor said, “Stamp the authority for her to be put into a house with other girls [inmates],” whereas we felt this was inappropriate. And this is what happened; she actually took a knife

to this other girl in the middle of the night when the girl was asleep. ... She's having surgery today, she's in hospital. It was quite a significant stabbing

As a consequence of this security breach the prison was locked down.

Protecting Patients From Themselves

The obligation to ensure the security of others also extended to protecting people from themselves. Preventing self-harm and suicide, particularly in patients known to have mental health problems and/or believed to be at increased risk of suicide, has long been a preoccupation of public and mental health services. This is an even greater concern in prisons, as rates of suicide and self-harm are far higher in the prison population than in the general community, in part as a result of social isolation, emotional deprivation, victimisation, and intimidation from other inmates and the guilt, shame, and existential challenge that frequently follows incarceration (Butler and Milner 2003).

Keeping prisoners safe and secure is therefore a major priority, with both custodial and health care staff being urged to be vigilant against suicide attempts, both on account of its likelihood and on account of the impact that it has on the prison population and on the institution itself. As one nurse succinctly put it:

Nurse 3, Maximum Security: We can't risk a death in custody.

Perhaps as a consequence of this concern, many of the health professionals in our study, particularly nursing staff, described how they had been acculturated by the prison context—adopting custodial values and norms in place of health care values and norms.

Nurse 3, Maximum Security: We've got to do something about these chronic, psychiatric, hopeless cases because they are so disruptive on other people. Self-harmers disrupt the whole unit.

While for some this was simply a matter of following policy or appropriately modifying one's practice consistent with the situation, for others this dual role created significant problems. This was particularly the case where practitioners were required to report self-harm to custodial authorities or to restrict women thought to be at risk of self-harm to a "safe cell."

Doctor 1, Maximum Security: One of the things becoming a major issue is the view of the custodial administration that women who suffer from any serious psychiatric disorder ... who seriously harm themselves [should be] put in white boiler suits having an officer sitting there but not allowed to say anything to them—not responding in any way. ... This is the very antithesis of therapy.

Protecting Themselves

As well as acting to protect the health and well-being of patients and of the (relevant) community for which they are responsible, in recent years increased attention has been drawn to the risks that clinicians face from infectious threats, from their patients, and from the context in which they work. While these security risks are evident in all health care settings, they are particularly salient in prison contexts. In our study the participants spoke of regularly undertaking security awareness courses, as are taken by clinicians everywhere, but they also spoke about other strategies that reflected their vulnerability. Clinicians spoke about protecting each other—doctors spoke about being protected by the nurses and nurses about being protected by the doctors and the correctional officers. And during team meetings strategies often were developed to "manage" dangerous patients. Clinicians also used informal policies to protect themselves, such as knowing the prisoner's crime so that they could make informed and "safe" judgements about which patients could enter the clinic unaccompanied by a correctional officer.

A “sight and sound” policy (that required constant support and surveillance) was perhaps the most obvious example of a policy designed to protect health care professionals working within the prison. In some circumstances, clinicians thought that this policy was appropriate.

Doctor 3, Maximum Security: Actually in some situations, some of my patients might be a bit violent if they are ill and there have been, for instance, threats like “I’m going to get [the doctor] next time.” The DCS staff will tell me that this person has said that, that they are out to get you. In those situations you take that seriously and you just alert the guard that this has occurred. In this situation I would see the patient on my own—but the guard is outside the door. They just look in from the window. So in some ways it is quite useful and it is not disturbing whatsoever.

Other clinicians, however, described how they did not comply with the policy because they believed that it compromised their therapeutic relationship with the patient and made it impossible for them to ensure privacy and confidentiality. For all of our participants, however, what was clear was that they made an assessment of the security threat posed to them by a particular situation or patient and used this assessment to determine whether they should see the patient within sight and sound, or just sight, of a correctional officer, or whether they should not comply with the policy at all.

Access

One central theme that arose in the interviews was the idea of blocked access to health care. Patients’ access to health care and health care professionals’ access to patients, both in their cells and in the prison system more generally, can be blocked by physical barriers—fences, wire, and doors—and by organisational procedures and policies. Accessing the patients proved to be difficult and, consequently, ethically problematic for most of the practitioners interviewed.

KW: What would be your central ethical dilemma?

Nurse 1, Maximum Security: Access, getting access to the women.

Access to patients can be blocked for several reasons, including the fact that inmates were transferred to different correctional facilities or had to make court appearances. Both custodial and judicial requirements overrode health care concerns.

Nurse 2, Minimum Security: But they can deny access. I’ve seen it before.

KW: Officers?

Nurse 2, Minimum Security: Yes, they won’t let us see certain inmates.

KW: Why?

Nurse 2, Minimum Security: It can be a punishment for the girls [the inmates], I’ve seen like officers not doing certain things for certain nurses that they don’t get along with.

There is no doubt that both social change and political policies, some of which have been given expression in legislation (e.g., “truth in sentencing”), have led to overcrowding in prisons. Unfortunately, the increase in the prison population has not resulted in a concomitant increase in staff. Too many patients and not enough health care and other staff mean that patients’ access to health care is reduced and, moreover, it is not equivalent to that of the general community.

Nurse 3, Maximum Security: We have a hundred more women than we should have and no extra staff. No more officers, no nurses, no more welfare people [psychologists]. And so the women themselves are more stressed because they are more crowded. They are locked in more often because there are less officers.

Formal policies and practices related to security are not the only things that block patients’ access to health care. Health care practitioners use informal practices to block patients’ access as well. Denying patients’ access to medications or to make appointments is a strategy used by some to cope

with difficult or aggressive behaviours by prisoners or when too many prisoners are seeking medication. It is also a strategy used when the clinics are understaffed.

Accessing outside health care facilities for their patients proved particularly problematic for health care practitioners as a direct result of Department of Corrective Services (DCS) policy and security procedures and because correctional authorities often prefer to minimise prisoner escorts as a security measure (Woodham 2005, 56).

Doctor 3, Minimum Security: So they might be waiting 12 months to get in to see a specialist about something and on the day of the appointment they find that after waiting 12 months to get in to see a specialist, there are a couple of emergency cases in the jail and their appointment gets cancelled, because the emergency is wanting to go out. So they've [inmates] got to wait another 12 months and that quite frequently happens, it's not uncommon. In terms of access, that's a problem.

Many of the doctors and nurses interviewed stated that they experienced problems organising escorts to outside health care facilities because of formal security policies. However, informal policies also interfered with the timely escort of patients to hospital. Health care practitioners reported that correctional officers, on occasions, questioned whether patients really needed to be transported to hospital.

Nurse 2, Minimum Security: I do know that when we send women up and say, "We are sending such a body [woman] out," [the custodial officers say], "Oh no, do they really have to go?"

Lack of available beds in public hospitals, particularly forensic beds, was problematic in the prison context. The transfer of seriously ill psychiatric patients to mental health hospitals, in particular, was an ongoing problem for doctors.

Doctor 1, Maximum Security: I often can't get them out because there are simply not enough beds—forensic beds at [the local Psychiatric] Hospital. As of last year we had the same number of beds we have had for years—that's six beds. At any one time we had 15 or so women suffering from clearly psychotic illness, continuing psychotic illness. Increase that to 12 beds and that is still not enough. I mean, at any one time we have a number of women waiting to go to hospital. There are two women who have been made forensic who are seriously ill, ought not to be in jail. I think it's a travesty that they are in a jail.

Lack of access to appropriate treatment was not confined to forensic beds, however, and was common to other specialities and procedures as well.

Doctor 2, Maximum Security: So someone who has got like a knee that needs an arthroscopy and she was saying, "Write a letter to my local doctor so he can make an appointment for me when I get on the outside." And I said, "Well if you were on the outside your local doctor would make this appointment much more easily." You know like if they've got someone in their local area who will bulk bill.

The other area of concern in terms of blocked access for some of the health care practitioners related to the supply of clean needles and syringes.

Nurse 2, Maximum Security: The fact that we don't offer a needle exchange program in this jail. ... Now on the outside, any intravenous drug user has access to new needles and syringes—they certainly do not in jail, and I'm very aware of this, so we offer education of how to clean needles and syringes knowing very well that under the circumstances they will probably go out and inject themselves with a blood-borne disease. It's a huge ethical issue.

In NSW health care practitioners must be accompanied by correctional officers if they are required to see patients outside of the clinic. This applies to patients whose movements are especially restricted for any reason, for example in a "safe cell," or if patients are unable to attend the clinic

because of ill health. These policies are required to ensure the personal security and safety of the attending health care professional. These policies, however, hinder health care practitioners' immediate access to patients.

Equivalence of Care: Inside and Outside

Ensuring that prisoners received equivalent care to that they would receive in the community was a major concern for many of practitioners interviewed. This was particularly the case both for women with psychiatric problems (particularly those diagnosed with psychoses) and for women with complex medical problems who often required access to sophisticated diagnostic and/or therapeutic technologies. The sheer number of patients, the overcrowding of prisons, and the relative under-resourcing of health care services also meant that health care practitioners often felt unable to provide adequate care for their patients.

Doctor 2, Maximum Security: I can come in some days I'm working and there will be 20 people written on the day that I'm there and I [think], "What do they expect me to do? No I can't see all these people."

The health care professionals interviewed often spoke in terms of inside and outside. This contrast had multiple meanings and contexts but always applied to access to, and equivalence of, health care.

Providing care "outside" (in the community), unless the patient was hospitalised, was particularly difficult for "political" reasons—because inmates lost access to their universal health care (Medicare) entitlements by virtue of being incarcerated. Consequently, patients and their clinicians were restricted in their ability to access health care outside the public hospital system. Being inside, then, limited the health care available to prisoner-patients and, for this reason alone, was construed by some of the health care professionals interviewed in this study as a denial of human rights.

Doctor 2, Minimum Security: They are not covered by Medicare ... and when you come into jail you lose all your rights. And because ... the NSW State Government is expected to look after all you need, including your health needs. So if someone has a cardiac problem or a gastric problem you've got to refer to the public hospitals.

Some practitioners explicitly contrasted their practice inside the prison walls to their outside practice. Rarely, practitioners thought the care similar, most notably in regard to the management of drug addiction within the prison and the community.

Most participants however, maintained that prisoners received a different and worse standard of care inside prison than the standard of care available to the general community.

Doctor 3, Minimum Security: I suppose that can be frustrating because you can make the diagnosis of depression, then listen to their concerns and rule out other things, and you can deal with the physical and can then put them on an antidepressant and get them to see the psychologist. But you can't actually do any cognitive behavioural therapy or crisis management stuff—you just don't have the time.

KW: Would they get that outside prison?

Doctor 3, Minimum Security: In my practice outside they would, they certainly would.

Women prisoners found it especially difficult to cope with their remorse and concern about their families who were on the outside. These worries inevitably cause health care problems ranging from insomnia to anxiety and proved a major challenge to nursing care in particular.

Nurse 2, Maximum Security: Recently, last week, I had a positive Hep B [hepatitis B] patient. This is highly infectious, and we had to do a contact tracing. This very young girl had a 4-year-old child who was in the care of foster parents and my duty of care was to notify the Department of Community Services to tell the foster carers to have the child screened. But this patient was in the room crying her eyes out because she only had five weeks to go

[in prison], and she saw that my contacting the foster parents about the child would jeopardise her ability to access her daughter when she was released. There was nothing I could do or say.

Divided Loyalties

Prisons deprive people of their liberty and their agency and are established (in broad terms) to ensure detention and security. In the stories told by the doctors and nurses who participated in this research, it was evident that the prison context not only constrained the usual goals of health care but also challenged and reshaped them. The evident prioritising of security concerns over health care was perhaps the clearest example of this.

Nurses and doctors working in prisons are required to report to the Department of Corrective Services (DCS) any knowledge they have about illicit drugs entering the prison system. While superficially this would appear justifiable, this requirement raises fundamental questions about the purpose of nursing and medicine in the correctional context and about whether the security obligations placed upon health staff in institutional settings can subvert their clinical obligations.

This is clearly at issue when one considers whether nurses or doctors should report specific patients to the custodial officers (as this poses a challenge to privacy and confidentiality within clinical relationships). But it is also at issue even when one considers whether knowledge about drug use on a larger scale ought to be reported to DCS administration. For while reporting drug use within the prison to the Governor may seem (ethically) appropriate, given that (unsafe) drug-taking may pose broader health risks to the prison population, there remains a question as to whether reporting this type of problem is a nursing or medical role, particularly given that health professionals are not employees of DCS.

Nurse 2, Minimum Security: Somebody might tell me they are getting a whole heap of speed coming in, and they have been using it and that's why they are in the state they're in. I called a girl in the other day who had been yelling at the nursing staff and said, "Hey, that's not like you," and she told me what she had been doing. So yep—I wrote a memo to the Governor saying I have received the information.

In the prison context, security concerns give rise to a range of organisational structures and policies, such as "safe cells," sight and sound policies, and policies for management of drug use that restrict a prisoner's access to clean needles and syringes. Some of these policies protect the jail, some protect individual patients from harm, while others protect clinicians and DCS workers. But these policies, including policies that protect health care practitioners and Justice Health from harm, may adversely impact on the provision of health care in prisons. And many of these policies may compromise the ethical and professional obligations of health care professionals working in correctional centres. In part, this is because health practitioners working in correctional centres must attend to security concerns not usually found in other health care contexts, and, in part, this is because they adopt a security role. This inevitably creates dual loyalties and compromises the relationships that health care practitioners have with their patients.

Discussion

It is clear from this research that context matters, not only to the provision of health care but also to ethics. For all the health care professionals working in these prisons, the institution (in the sense described by Goffman) profoundly shaped and challenged the ethical and professional obligations they had to their patients. This is a critical insight, both because it is a reminder of the contribution that sociology and anthropology make to bioethics and because it illustrates the deeply political and social nature of practical and professional ethics.

While the results of this study mirror other empirical studies of health care provision in prisons, particularly the ethical issues associated with the management of risk and violence (Crampton 2007;

Maeve 1997), the tension between health and custodial concerns (Veal 2001), and the challenge of dealing with dual loyalties (Holmes, Perron, and Michaud 2007), by focusing on professional ethics this study provides a more nuanced account of the impact of the prison context on moral virtue and professional practice. The accounts of the health care professionals who participated in this study make clear how the provision and ethics of health care may be compromised by the physical design of the prison, the institutional policies and practices restricting movement of prisoners and practitioners, the focus on maintaining control and security, and the very purpose of the prison and prison system itself.

Prisons, of course, provide a paradigmatic example of legitimate coercion and state-sanctioned restriction of liberty and agency. They ensure the secure detention of inmates both through physical means (secure perimeters, control of entry and egress, cells and locks) and through organisational policies, including those concerned with the security classification of inmates, and the regulation of all aspects of life, work, and movement within the prison system. All of these structures, policies, and practices impact upon the provision of health care and raise practical as well as ethical and professional difficulties for health care professionals seeking to provide care to prison inmates. (This was particularly evident in descriptions of overcrowding and under-resourcing, of security classification of women with babies, and of access to health care outside the prison system, to name a few.)

Perhaps unsurprisingly, concerns about security dominated the accounts provided by the doctors and nurses in this study of the experience of providing care within a prison context. These included concerns not only for the health, well-being, and (ontological) security of their patients, but also for their own personal security and the security of other health care workers, DCS staff, and other prisoners. While all expected that there would be, and should be, policies and practices that would secure each of these groups, at the same time many of these policies—such as those requiring constant support and surveillance (sight and sound policies)—challenged their commitments to their patients' best interests and their capacity (and willingness) to ensure confidentiality and privacy. Likewise, institutional requirements that health care providers report drug use, intoxication, and risk of harm were at once ethically justifiable—protecting the interests of both individuals and the prison population—and ethically questionable—forcing practitioners to adopt a security role and compromising their relationship with their patients.

In much the same way, the physical design of the prison, the highly enforced control of space, entry and exit points, movement both within the prison and at its point of contact with the world outside (including external health care services) inevitably shaped how health care was provided and constrained and challenged the capabilities and ethical commitments of the health care professionals working within the prison.

While care must be taken in generalising the results of this study to other settings, both because this study relied upon self-reporting and describes only the experience of health care professionals working within women's prisons in one state of Australia, it is likely that contextual determinants of health care practice reported here are relevant to other countries, as they describe features of prisons that are universal. Prisons everywhere restrict liberty and choice and agency—all values that are central to the function and ethics of health care. And all prisons restrict movement and control social and professional relationships—things that are crucial to the successful delivery of health care and to the therapeutic relationships upon which it is based.

In thinking about the ethical challenges that health care practitioners working in institutional contexts face, we must have conceptual clarity and we need to be clear about what the ethical values and virtues are that inscribe the health care professions. But equally we need to understand (through both theory and empirical study) the complex nature of institutions and the way in which context significantly impacts upon health care practice and ethics. This does not mean, of course, that we should interrogate decisions that health professionals working in prisons and in other

institutions make or critically analyse the way they behave. Nor does it mean that we should excuse situations where health practitioners act in ways that are ethically unconscionable, are ignorant of the salience of divided loyalties, or are unable to see that there may be alternatives to being complicit with state-sanctioned “violence” against others. Rather, it is a reminder that normative analysis should be informed not only by philosophical clarity and rigor but by a deep (empirical) understanding of the actual practice of health care in institutional settings and the enormous impact that this context has on professional behaviour and ethics.

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