Ethics at the margins: An empirical study of the experience of doctors and nurses working in women's prisons in NSW, Australia

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Dedication

I dedicate this work to my two daughters: Louise Emma and Alexandra Claire.

Abstract

Background: Health care practitioners provide health care in a variety of contexts. In some contexts the professional and ethical obligations of health care practitioners will be distorted. This will usually occur in institutional contexts which have significant deprivation of individuals' liberty *as their raison d'être*. So, health carers who work in prisons see patients or clients who have significantly less liberty than do patients and clients elsewhere; and they see them in a context which is structured precisely to give sustained expression to this lack of liberty. This lack of liberty which characterises correctional contexts will impact on patients, the delivery of health care and on health care practitioners.

Aims: This project aimed to understand how the prison context impacts on ethical and professional health care practice via examination of health care professionals' experience. More specifically, the project aimed to understand the limits and possibilities of clinical freedom in confined contexts and to examine the adequacy of ethical principles and Codes of Ethics for explaining or describing the ethical obligations of health care practitioners working in the prison context.

Methods: Qualitative methods were used to carry out an in-depth analysis of the impact of context on the ethical and professional obligations of doctors and nurses working in women's prisons in New South Wales, Australia. Data sources consisted of in-depth, semi-structured interviews with doctors and nurses and field observation. Interviews were conducted with clinicians working at the maximum and minimum security correctional centre to enable exploration the impact of different levels of security on prison health care practice and practitioner-patient relationships. Field

observation contributed to gaining an understanding of the prison context and the conditions under which clinicians practice. The data were thematically coded for anticipated and emergent themes.

Results: Providing health care to prisoners is complex and difficult. Clinicians reported clinical isolation, tension between health care and custodial values, and difficulties dealing with manipulative, abusive and violent patients. Clinical freedom was curtailed by political and custodial security policies and practices which impacted negatively on patients' ability to access health care and practitioners' ability to provide health care to an equivalent community standard.

Conclusions: This research shows that clinicians found meeting their ethical and professional obligations to patients problematic because health care practice was subordinated to security concerns and custodial values. The primacy of correctional and security values and concerns requires practitioners to adapt their practice which in turn, compromises the clinician-patient relationship. Principle based ethics provides an adequate theoretical framework for understanding the ethical complexities of clinical practice in the prison context.

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Abbreviations

AMA	Australian Medical Association
AMS	Aboriginal Medical Service
ANMC	Australian Nursing and Midwifery Council
AOD	Alcohol and other drug
BC	*The birth of the clinic*
BMA	British Medical Association
CHS	Corrections Health Service
CMS	Colonial Medical Service
DCS	The Department of Corrective Services
DP	*Discipline and Punish*
HCCC	New South Wales Health Care Complaints Commission
ICAC	Independent Commission Against Corruption
ICAC	NSW Independent Commission Against Corruption
ICN	International Council of Nurses
JH	Justice Health
KW	Karolyn White
NSW	New South Wales
SMR	United Nations *Standard Minimum Rules for the Treatment of Prisoners*
WHO	World Health Organisation

Chapter One: Introduction

Health care practitioners provide care in a variety of contexts, including the home, the battlefield and public and private clinics. More recently, health care practitioners have provided health care 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 distorted. This will usually occur in institutional contexts which have significant deprivation of individuals' liberty *as their raison d'être*. In this they differ from other, more usual contexts, such as the hospital. Hospitals restrict the liberty of patients in order to enable carers to achieve the goals of these institutions, that is, therapeutic benefit. Thus, restriction of liberty is not their *raison d'être*; it is *instrumental for* achievement of the goals of healthcare. So, health care practitioners who work in prisons see patients or clients who have significantly less liberty than do patients and clients elsewhere; and they see them in a context which is structured precisely to give sustained expression to this lack of liberty. This lack of liberty which characterises correctional contexts will impact on patients, the delivery of health care and on health care practitioners.

International associations such as the United Nations,[1] international professional bodies including the International Council of Nurses (ICN)[2] and British Medical

[1] United Nations, *Standard Minimum Rules for the Treatment of Prisoners,* Geneva, 1955. Available at http://www.unhchr.ch/html/menu3/b/h_comp34.htm. accessed 3.5.2006.
[2] International Council of Nurses, *Nurses' role in the care of detainee and prisoners,* revised 2006. Available at http://www.icn.ch/psdetainees.htm. accessed 8.1.08.

Association (BMA),[3] and national professional associations including the Australian Medical Association (AMA)[4] 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.

Published empirical research on prisons concentrates mainly on the health status of prisoners and the management of patients in prison, particularly the transmission of infective diseases and mental health issues. In the main, empirical studies published on the experience of health care practitioners working in the prison context do not specifically explore ethical issues. Where ethical issues are specifically raised and explored they are not explored *empirically*.

This study aims 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. The data show that clinician's professional and ethical obligations are compromised by the prison context.

[3] The British Medical Association *The Medical Profession & human Rights Handbook for a changing agenda,* Zed Books, London, 2001.
[4] The Australian Medical Association, *Health care of prisoners and detainees,* 1998. Available at http://www.ama.com.au/web.nsf/doc/SHED-5G4V6U. accessed 3.11.07.

Because of the paucity of published research specifically on the impact of the prison context on clinicians' moral and professional obligations to patients, this research takes a qualitative approach to gather exploratory information. Interviews were conducted with nurses and doctors working at the two dedicated women's prisons in New South Wales (NSW), Australia with the permission of Corrections Health Service (CHS)[5] and the Governors of the two prisons. In order to explore the impact of different levels of security on prison health care practice and practitioner-patient relationships two women's prisons were selected to include all three security classifications (maximum, medium, and minimum). Women's prisons were chosen to minimise the impact of the prisoner's gender on the practitioner-patient relationship, because little research had been conducted in this environment, and by understanding context, women's health care could be improved.

Chapter 2 of this thesis outlines professional ethical norms in order to evaluate whether working in prisons challenges clinicians' ethical standards and values, and, secondly, whether the prison context distorts these standards and values. Given that the *raison d'être* of prisons is the radical deprivation of liberty, liberty is also discussed. I also discuss international declarations and codes relevant to the prison context. Chapter 2 includes a review of the literature on ethics and prisons. Three issues arising from the literature, values tension, dual loyalties, and exceptionalism are examined.

I argue that there is little disagreement over the state sanctioned use of coercion (the radical deprivation of liberty) on the grounds of protecting others from harm. Nor is

[5] The name of Corrections Health Service was changed to Justice Health in 2004. I have continued to use the title Corrections Health Service in this thesis.

there disagreement about the moral basis of health care. It is widely accepted that health care is a moral as well as social good. There is more disagreement, however, about the best theoretical approach to professional ethics. Scholars have reached agreement that health care professionals ought to be competent and that notions of moral obligations to patients must include such principles as respect for persons and autonomy, justice, beneficence, do no harm, veracity, best interests, and confidentiality.

In Chapter 3, I discuss the concept of context. I explore theories of total institutions and their possible relevance to health care in prisons. I also discuss historical and contemporary Australian prisons, the role and purpose of the Department of Corrective Services (DCS) and CHS. I then consider the prison population and their health problems. Finally, I discuss government inquiries into health care provision in the NSW correctional context and the impact of the inquiries on the provision of health care.

In Chapter 4 the basic information about participants, materials and methods, including the study design, research methods, and selection of the correctional centres, the study population and data analysis are outlined.

Chapter 5, 6, 7 and 8 explore the data. Chapter 5 outlines the results of one of the central themes of this thesis: the ethical values, virtues, standards and feelings articulated by the participant health care professionals and the way in which they were eroded or changed by the prison context.

In Chapter 6 themes relating to the social context are explored. The social context refers to persons and groups which the health care practitioners referred to, and in the main dealt with, on a regular basis. This includes patients and other occupations. Other occupations refer to Corrections Health Service administration, the Department of Corrective Service's administration and staff including correctional officers, public hospital and specialist health care practitioners and magistrates. The data suggest that Goffman's work on the impact of total institutions on transforming inmates is under theorised. The data also indicate evidence of acculturation of health care practitioners with custodial values and the issue of dual loyalties.

In Chapter 7, security and its role in the organisational context are discussed. Security is the overriding value in prisons, so it shapes the organisational context and its policies. Security however encompasses a variety of concerns. The various security concerns were explored to understand their impact on health care and the ethics of health care. Health care practitioners working in the prison context are required to adopt security roles. The data showed that requiring clinicians to fulfil security functions compromises their ethical obligations and the practitioner-patient relationship.

Chapter 8 explores the physical context. While the physical context impacts on the provision of health care in prisons, it was not an important feature in the discussions with research participants.

In Chapter 9 the data are summarised and the study limitations discussed. I argue that despite limitations the study is, nonetheless, valid. The evidence from this study

showed that clinicians found meeting their ethical and professional obligations to patients problematic because of institutional security requirements and arrangements. This effectively meant subordinating health care practice and values to security concerns and custodial values. We know this because principle based ethics provide an adequate theoretical framework for understanding the ethical complexities of clinical practice in the prison context.

Correctional centres are places of tensions. These tensions are caused by the different values between health and custodial concerns and because custodial and various security concerns and values are privileged over health care concerns and values. The primacy of correctional and security values and concerns and policy that requires clinicians adopt security roles leads to compromised clinician-patient relationship.

Chapter Two: Ethical and professional practice

2.0 Synopsis

In this chapter I will outline a coherent, minimal account of professional ethical standards in order to evaluate two things: whether working in prisons challenges ethical standards and, secondly, whether the prison context distorts these standards and values. In order to do so I will first consider the concept of liberty and then establish the standards of ethical practice. This will enable evaluation of whether professional and ethical practice and obligations are challenged, modified or subverted by the prison context.

2.1 Liberty and the Prison Context

Given that the *raison d'être* of prisons is the radical deprivation of liberty, no discussion of ethics relevant to the prison context would be complete without consideration of this moral concept.

Liberty is an important concept in all moral and political theories, though its significance and emphasis differs. Socialist theories do not deny the importance of individual liberty, but this is not seen as primary, as is the concept of equality. Communitarians, in the main, emphasise the centrality of community, but nevertheless recognise the significance of individual liberty. For liberals, liberty is primary. The best social and political arrangements in which individuals can exercise

their liberty is, however, contested. Hobbes,[1] for example, argued individual liberties could only be guaranteed by a strong central authority. Mill,[2] on the other hand, sought to maximise individual liberty and sovereignty by restricting the role of social and governmental control. Rawls,[3] instead of grounding liberty in individuality, autonomy or equality, argues it is the first principle of justice.

Critical discussions on liberty then not only focus on the importance of liberty to and for persons, and the meaning and scope of the term, they also focus on the limits, constraints, and the legitimate or otherwise use of coercion. In the following discussion I will explore the concept of liberty. Given that Australia is, socially and politically, liberal, and its prisons and health care is a product of such ideology and practice I will confine my discussion to liberal scholarship on liberty.

Freedom and liberty are frequently used interchangeably. Feinberg,[4] however, argues that liberty is a special kind of freedom: it is political freedom. Berlin[5] uses the two words to mean the same thing. It is irrelevant, for the purposes of this discussion, which understanding is correct because prisoners are denied freedom in both the Feinberg and Berlin senses as they are not free and are deprived of their liberty (political freedom in Feinberg's sense).

Feinberg argues that freedom, as distinct from liberty, can be understood as dispositional. By that he means that a person is free "only to the extent that he can do

[1] Hobbes, T, *Leviathan*, Macpherson, CB. (ed) Penguin, Harmondsworth, 1968.
[2] Mill, JS. *On Liberty,* Himmelfarb, G.(ed) Penguin, London, 1974
[3] Rawls, J. *A theory of justice,* Oxford University Press, London, 1972.
[4] Feinberg, J. *Social Philosophy,* Prentice-Hall, Englewood Cliffs, 1973, p.7.
[5] Berlin, I. *Four essays on liberty,* Oxford University Press, Oxford, 1969, p.121.

what he wants to do when he wants to do it."[6] To be free, then, a person must not be constrained from doing the thing she or he wants to do. Freedom can be constrained internally and externally. Internal constraints are those internal to a person; Feinberg includes such things as sore muscles and refractory lower desires. External constraints include those that come from without such as impoverishment. Constraints can also be positive or negative: negative is the absence of constraints and positive is something that constrains our freedom, other than the absence of constraints.

Political freedom or liberty, Feinberg argues, exists in the absence

> of that one special kind of constraint called *coercion*, which is the deliberate forceful interference in the affairs of human beings by other human beings. Coercion takes two main forms: direct forcing or preventing, such as the prodding with bayonets or imprisoning, and a threat of harm clearly backed up by enforcement power.[7]

Berlin too, discusses both negative and positive liberty. Liberty is defined thus: "I am normally said to be free to the degree to which no man or body of men interferes with my activity."[8] Freedom can be constrained negatively; that is the intentional interference by persons or coercion. "You lack political liberty or freedom only if you are prevented from attaining a goal by human beings."[9] Berlin's definition of the positive conception of liberty is close to the meaning of autonomy (construed as self-government).

> I wish my life and decisions to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not of other men's, acts of will. I wish to be a subject, not an object; to be moved by reasons, by

[6] Feinberg, J. *op cit,* p.6
[7] *Ibid,* p.7.
[8] Berlin, *op cit,* p.122.
[9] *Ibid.*

> conscious purposes, which are my own, not by causes which affect me, as it were, from the outside…[10]

It seems to me, however, that the liberty-as-autonomy notion represents only one kind of freedom: the freedom to rationally self-govern. While I think this kind of freedom is important, indeed it would be hard to argue against the desire to be treated as a self-directed subject, it nonetheless privileges a particular desire. Moreover, liberty involves desires and choice, while autonomy provides the capacity for rational choice.

Mill does not advantage a particular desire; instead he construes liberty in the negative sense and consequently was strongly opposed to many, if not most, types of coercion.[11] In a much quoted tract he explains:

> [T]he object of this essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties or the moral coercion or public opinion. That principle is that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That is the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part which merely concerns him, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.[12]

As Berlin explains:

> Mill believes in liberty, that is, the rigid limitation of the right to coerce, because he is sure that men cannot develop and flourish and become fully

[10] *Ibid,* p.131.
[11] Mill, JS. *Op cit.*.
[12] *Ibid,* pp.68-70.

> human unless they are left free from interference by other men within a certain minimum area of their lives, which he regards as – or wishes to make - inviolable.[13]

Mill is not alone in construing liberty negatively. Carritt also defines it thus: "the power of doing what one would choose without interference by other person's action."[14] He goes on to argue that imprisonment with manacles would constitute a maximum interference with liberty.[15]

Imprisonment is a recurring example of coercion, "[T]o coerce a man is to deprive him of his freedom"[16] Feinberg, following Mill,[17] argues six grounds for legitimate coercion which include both self-regarding and other-regarding behaviour:

1. To prevent harm to others:
    a. Injury to individual persons *(The Private Harm Principle)*
    b. Impairment of institutional practices that are in the public interest *(The Public Harm Principle)*
2. To prevent offense to others *(The Offense Principle)*
3. To prevent harm to self *(Legal Paternalism)*
4. To prevent or punish sin *(Legal Moralism)*
5. To benefit self *(Extreme Paternalism)*
6. To benefit others *(The Welfare Principle)*

Feinberg argues these principles are

> neither necessary or sufficient conditions for justified coercion, but rather specifications of the *kinds* of reasons that are always relevant or acceptable in support of the proposed coercion... Each principle states that interference might be permissible *if* (but not *only if*) a certain condition is satisfied.[18]

Legitimate imprisonment could be justified on several of the above grounds, but certainly principle 1. Rawls argues penal sanctions are compatible with justice

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[13] Berlin, *op cit,* p.190.
[14] Carritt, EF. Liberty and Equality in Quinton, A. (ed) *Political Philosophy,* Oxford University Press, Oxford, 1967, p.133.
[15] *Ibid,* p.134.
[16] Berlin, *op cit,* p.121.
[17] Feinberg argues that most critics of Mill would reject the harm principle because it is too liberal and does not allow enough interference (p.33).
[18] *Ibid.*

because they are grounded in the principle of responsibility, which itself is derived from the principle of liberty. Moreover, the coercive powers of government and its instrumentalities, he argues, are necessary for the stability of social cooperation. Coercive agencies are thus a stabilising arrangement – they ensure security. Coercive agencies (penal establishments) are necessary to ensure liberty, and the ultimate punishment – imprisonment - is the drastic curtailment of liberty.[19]

> In prison the government may dispose of the liberty of the person and of the time of the prisoner; from then on, one can imagine the power of the education which, not only in a day, but in the succession of days and even years, may regulate for man the time of waking and sleeping, of activity and rest, the number and duration of meals, the quality and ration of food, the nature and product of labour, the time of prayer, the use of speech and even, so to speak, that of thought, that education which, in the short, simple journeys from refectory to workshop, from workshop to the cell, regulates the movements of the body, and even, in moments of rest, determines the use of time, the time-table, this education, which, in short, takes possession of man as a whole, of all physical and moral faculties that are in him and of the time of which he is himself.[20]

Foucault argues that the self-evident character of the prison is based on the deprivation of liberty. "How could prison not be the penalty *par excellence* in a society in which liberty is a good that belongs to all in the same way and to which each individual is attached."[21] This egalitarian punishment – we all have the same liberty after all – is not, however, the only function of the prison, or even the primary one.

> One thing is clear: the prison was not at first a deprivation of liberty to which a technical function of correction was later added; it was from the outset a form of 'legal detention' entrusted with an additional corrective task, or an enterprise for reforming individuals that the deprivation of liberty allowed to function in legal system. In short, penal imprisonment, from the beginning of the nineteenth century, covered both the deprivation of liberty and the technical transformation of individuals.[22]

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[19] Rawls, *op cit*, p.242.
[20] Lucas, C. *De la réforme des prisons,* 1836, pp.123-4, cited in Foucault, M. *Discipline and Punish: the birth of the prison,* Sheridan, A. (trans) Penguin Books, London, 1977, p.236.
[21] Foucault, M. *Ibid,* p.232.
[22] *Ibid,* p.233.

The radical deprivation of liberty – for corrective and protective purposes – impacts profoundly on the lives of inmates. Indeed Welch, following Foucault, argues a central purpose of prisons is to induce emotional pain and suffering in wrongdoers.

> ... inflicting emotional pain on lawbreakers has remained the prevailing rationale for incarceration, where anguish is achieved by the deprivation of liberty, goods and services, heterosexual relationships, autonomy and security.[23]

In summary, liberty is moral good, necessary for full humanity. State sanctioned punishment by depriving persons of their liberty is legitimate to ensure the stability and security of society. This is not the only function of penal establishments; they also perform a corrective or transformative function.

2.2 Health as a Social and Moral Good

Health and the provision of health care intuitively seem important. Without good health and well-being we are, to a lesser or greater degree, limited and restricted in what we can do and achieve. The importance of health and health care, in terms of human rights, has been proclaimed in the *Universal Declaration of Human Rights*.[24] The World Health Organisation (WHO) states certain principles, including health, are basic to the *happiness* and *security* of all people. Health, according to WHO, is a state of physical, mental and social well-being and that the enjoyment of the highest attainable standard of health is a fundamental right of all

[23] Welch, M. *Ironies of imprisonment,* Sage Publications, Thousand Oaks, 2005, p.72.
[24] United Nations, *Universal Declaration of Human Rights,* 1948.

people. Moreover, governments have the responsibility to provide adequate health services to citizens.[25]

The WHO principles define health holistically and, more importantly, link health specifically to justice. Thus health care and its provision are not only a social good, they are a *moral* good. Much of the bioethics literature over the previous twenty to twenty-five years has been involved in theorising and discussing this moral good under the broad category of justice which has included establishing rights to health care, rationing and access issues.[26] Norman Daniels, for example, argues health care is an important social good and its distribution is grounded in a particular construal of justice: equality of opportunity. He argues health needs are:

> important to maintaining normal species functioning, and in turn, such normal functioning is an important determinant of the range of opportunity open to an individual.[27]

Green too argues that access to health care is an important feature of "a theory of justice and a just social system".[28] He goes on to reject grounding a right to health care in equality of opportunity; rather, he argues that health care should be understood as one of Rawls's basic primary goods.

> The intuitive idea is that access to healthcare, like all basic primary goods, is important because it is instrumental to the pursuit of whatever other values we might have.[29]

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[25] The World Health Organisation, *Constitution of the World Health Organization.* Available at http://www.searo.who.int/EN/Section898/Section1441.htm accessed 15.5.08.
[26] Brock, D. Broadening the Bioethics Agenda, *Kennedy Institute of Ethics Journal,* 10:1, 2000, p.22.
[27] Daniels, N. Health-care needs and distributive justice, *Philosophy & Public Affairs,* 10:2, 1981, p.146. See also Daniels, N. Justice, health, and healthcare, *American Journal of Bioethics,* 1:2, 2001. A more extended discussion of Daniels (and Rawls) will be undertaken in Chapter 10.
[28] Green, RM. Access to healthcare: going beyond fair equality of opportunity, *American Journal of Bioethics,* 1:2, 2001, p.22.
[29] *Ibid.*

Not all philosophers and bio-ethicists accept the 'rights based' approach to access issues in health care. Buchanan,[30] for example, argues that theories which ground health care rights claims in justice cannot provide a firm basis for this right. Instead, he argues for non-rights based enforced beneficence to a decent minimum of health care. Communitarian and feminist authors have been highly critical of traditional arguments about access to health care and, in particular, health care rationing.

While there is disagreement at the level of theory about how to ground health care in justice and to provide, allocate, and ration health care resources including health care practitioners. And while there is disagreement over the importance of health and health care to living a good life, human rights, liberty rights, maximising public utility, reflecting central community standards, equality, equality of opportunity, and so on, there is little disagreement over the moral, social and political importance of health.

2.3 *Ethical Health Care Practice*

Health and by extension health care, then, are argued to be a social and moral good. It follows that those who provide health care are employed in moral work. Seedhouse[31] puts this strongly when he argues that health is an inherently moral endeavour and health work is essentially and intrinsically moral because through such work human potential can be realised or maximised.

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[30] Buchanan, AE. The right to a decent minimum of health care, *Philosophy & Public Affairs,* 13:1, 1984, p.55.
[31] Seedhouse, D. *Ethics: the heart of health care,* 2nd edn, Wiley, Chichester, 1998.

Because health and health care is both socially and morally important, particular and particularly high standards are expected of health care providers. While there is much disagreement about the right approach or theory of ethics, it is clear that there is little disagreement about the importance of ethics. In this section I will provide an outline of professional standards of ethical practice. While I rely heavily on the work of Beauchamp and Childress, and do so for specific reasons outlined shortly, I do not wish to imply that any one particular theory of ethics or professional standards is superior. My purpose is not to present an ideal of ethical practice. Instead, it is to articulate accepted ethical standards of professional health care practice to ascertain whether clinicians working in the prison context can maintain these standards and to evaluate the impact of context.

2.3.1 Definition of Terms

Before beginning the discussion on ethics and health care, it is worthwhile sorting out key terms and concepts. This is important because terms such as ethics, bioethics, medical ethics and nursing ethics, are used to mean similar things or, alternatively, used to mean different things. According to *A Dictionary of Philosophy* the lay meaning of ethics:

> suggests a set of standards by which a particular group or community decides to regulate its behaviour- to distinguish what is legitimate or acceptable in pursuit of their aims from what it is not.[32]

From this understanding we can distinguish medical or health care ethics from say police ethics in that the ethics appropriate to and for each group may differ because of the various roles undertaken. This reading of ethics is role specific but broadly

[32] Fles A. (ed) *A Dictionary of Philosophy,* Pan Books, London, 1984, p.112.

connected to, but different from, the philosophical term, which can be defined as follows:

> an investigation into the fundamental principles and basis concepts that are or ought to be found in a given field of human thought or activity.[33]

Bioethics refers to ethics applied to the biological sciences.[34] Biomedical ethics then is ethics applied to the biological sciences including medicine, nursing, and allied health.

The terms ethics and morals have different roots, the former Greek and the latter Latin. The terms, however, are frequently used interchangeably. While there are philosophical differences between the two, for the purposes of this thesis the two terms will be used to mean the same thing. This is consistent with the lay meaning of the terms and how they are used in ethics (including medical, nursing, and health care) and bioethical texts.

2.3.2 Bio-ethical and Relevant Texts

It would be impossible to begin a discussion about bio-ethical texts without beginning with Beauchamp and Childress's seminal work, *Principles of Biomedical Ethics.*[35] I use this text as a basis for discussion about ethical and professional values for two reasons. First, CHS define appropriate ethical and professional practice in terms of the ethical principles similar to those articulated by Beauchamp and Childress (among

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[33] *Ibid.*
[34] Kerridge, I. Lowe, M. McPhee, J. *Ethics and law for the health professions,* 2nd edn, The Federation Press, Sydney, 2005, p.1.
[35] Beauchamp, T. Childress, J. *Principles of biomedical ethics,* 5th edn, Oxford University Press, Oxford, 2001.

others).[36] Secondly, health care ethics has been, and continues to be, discussed in terms of rights, duties, virtues, and principles. Beauchamp and Childress argue all these approaches, as well as context, must be taken into consideration in bio-medical ethics.

Their book sets out moral norms as the basis for bio-medical ethics. They argue norms from common morality, principles from classical moral theory and traditional codes, together with professional and moral responsibilities derived from the institutions, practices and traditions of the various professions, give rise to the bio-medical ethics expressed as principles. The moral principles function as an analytical framework:

> [T]hat expresses the general values underlying rules in the common morality... [and] can then function as guidelines for professional ethics.[37]

2.3.2.1 Character and Virtues

Beauchamp and Childress discuss moral character and professional virtues early in the text and before their substantive discussion of the biomedical principles. They argue character matters because it disposes health care professionals to act in accordance with moral principles and rules. Moreover, professions inculcate traditional virtues and obligations, societal expectations and standards of professional merit which are derived from health care relationships.[38] Beauchamp and Childress outline five moral virtues of particular importance to health care and derived from professional-patient relationships. These central and widely acknowledged virtues,

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[36] See for example Gillon, R. Medical Ethics: Four principles plus scope, *British Medical Journal,* 309, 1994, pp.184-8.
[37] *Ibid,* p.12.
[38] *Ibid,* p.30.

they argue, are compassion, discernment, trustworthiness, integrity and conscientiousness.[39]

Compassion is an other-regarding virtue which:

> combines an attitude of active regard for another's welfare with an imaginative awareness and emotional response for deep sympathy, tenderness, and discomfort at another's misfortune or suffering.[40]

In the health care context compassion is usually a response to others' pain, suffering and/or disability. Health care practitioners who lack compassion, Beauchamp and Childress maintain, "[O]ften fail to provide what patients most need."[41] Compassion must, however, be tempered with impartial reflection and reason.

Discernment is the ability to make practical judgements without being overly influenced by unnecessary or irrelevant considerations. Discernment also involves knowing the most appropriate response to make; it is being sensitively attuned to the specific needs of particular patients. Beauchamp and Childress suggest the doctor knowing whether a person needs comfort or privacy as an example of discernment.[42] Discernment, an other-regarding sensitivity, is clearly important in the nursing context. Lawler, for example, discusses how good nurses pick up on and work to minimise their patient's embarrassment.[43]

Trust and trustworthiness are prominent in the professional-patient relationship. Beauchamp and Childress argue trust involves confidence "that another will act with

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[39] *Ibid,* p.32.
[40] *Ibid.*
[41] *Ibid,* p.33.
[42] *Ibid,* p.34.
[43] Lawler, J. *Behind the screens: nursing, somology, and the problem of the body,* Churchill Livingstone, Melbourne, 1991.

the right motives and appropriate moral norms."[44] All the authors discussed in this chapter considered the virtue of trust vital to health care practice and the practitioner-patient relationship.

Kerridge, Lowe and McPhee, for example argue trust is centrally important to the practice of medicine and explain why this is so.

> Those who are ill and require care do not have the knowledge or expertise necessary to cure their ills and they can never know everything relevant to their care or develop the skills needed to care for themselves. They must *trust* that those caring for them have these skills, use their knowledge wisely, respect them and have their best interests at heart... *Trust* is fundamental to the health professional-patient relationship (emphasis added).[45]

Berglund also raises trust in her discussion of the professional-patient relationship. She argues that central to this relationship is trust.

> Clients and health professionals engage in client-carer relationships with certain expectations of each other. One expectation held by carers... is that clients will *trust* you and will reveal their problem in detail, so that their care can progress. This disclosure on the part of the client requires them to trust the carer (emphasis in original).[46]

Rogers and Braunack-Mayer[47] write specifically for general practitioners and argue that while beneficence, respect for patient autonomy and confidentiality are important ethical values, trust is the crucial and defining feature of the doctor-patient relationship. Trust, which they define as being optimistic about particular persons, is inherently important in the health care relationship for both moral and therapeutic reasons. It is morally important because trust involves recognising and respecting another's individuality, independence and autonomy. It is therapeutic because it can

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[44] Beauchamp and Childress, *Op cit,* p.34 .
[45] Kerridge *et al*, *op cit.* p.120.
[46] Berglund, C. *Ethics for health care,* 3rd edn, Oxford University Press, South Melbourne, 2007, p.92.
[47] Rogers, W. Braunack-Mayer, *Practical ethics for general practice,* Oxford University Press, Oxford, 2004.

redress the power imbalance between patient and doctor. While I agree trust is morally important in the practitioner-patient relationship, Rogers and Braunack-Mayer's argument that trust is therapeutic because it is can redress the power imbalance between practitioners and patients is problematic: the power imbalance is always inherent in this relationship.

Trust is not uni-directional; ideally doctors should also trust their patients. Rogers and Braunack-Mayer argue doctors ought to be able to trust their patients in three ways:

> (a) Motive: ...trusting that patients are genuinely seeking medical care and share the aim of diagnosing and managing a health problem....
> (b) Testimony: ...trusting that patients are telling the truth without too many exaggerations or omissions...
> (c) Competence: ...trusting that patients are competent, both in terms of the general sense of understanding information and in the practical sense of being able to cooperate with management.[48]

Rogers and Braunack-Mayer's third claim is concerning. If doctors followed the suggestion that they ought to be able to trust that their patients were competent it would do away with any obligation that doctors must *determine* whether their patients are competent.

Integrity is the next moral virtue necessary for ethical practice discussed by Beauchamp and Childress. Integrity refers both to integration of moral character and soundness of moral character. Thus integrity requires an integrated self, as well as being faithful to moral ideals and being able to defend them. The importance of integrity becomes apparent when we consider what it would mean if our health care

[48] *Ibid,* p.21-22.

practitioner lacked integrity by being self-deceptive, or dishonest, primarily self-interested, insincere and, most importantly, devoid of moral convictions.

The final virtue is conscientiousness. This, Beauchamp and Childress explain, is an expression of integrity.

> An individual acts conscientiously if he or she is motivated to do what is right because it is right, has tried with due diligence to determine what is right, intends to do what is right, and exerts an appropriate level of effort to do so.[49]

Beauchamp and Childress also argue that the moral virtues are related to the moral principles because principles and rules have a corresponding virtue. Thus the principle of respect for autonomy has the virtue of respectfulness, beneficence – benevolence, veracity – truthfulness, and so on. This point is not uncontroversial. Campbell, for example, argues "judgements of character form part of the *content* of morality – they are not derivative from acceptance of some set of deontic imperatives, but complementary to them (emphasis in original)."[50]

2.3.2.2 Ethical Principles – Autonomy

The four general, equal, *prima facie* principles, which form Beauchamp and Childress's analytic framework, are respect for autonomy, non-maleficence, beneficence, and justice.

Autonomy literally means self-rule. Beauchamp and Childress concentrate their discussion of autonomy on autonomous action. They claim that there are three

[49] Beauchamp and Childress, *op cit,* p.37.
[50] Campbell, AV. The virtues (and vices) of the four principles, *Journal of Medical Ethics,* 29, 2003, p.293.

conditions of autonomous action whereby normal choosers act "(1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action."[51] Further, they argue autonomy is a matter of degree, a continuum. Respect for autonomy acknowledges a person's right to make decisions for themselves, based on their personal values and beliefs. It thus involves respectful attitudes and respectful and enabling action. The principle of respect for autonomy, they maintain, is supported by both deontological (Kant) and consequentialist (Mill) theories.

The importance of autonomy and respect for persons is acknowledged in all the ethics/bio-ethics texts I examined. Campbell, Charlesworth, Gillett and Jones,[52] for example, argue that respect for persons, understood from an Aristotelian perspective, is an important feature of good health care. This understanding of respect for persons obligates practitioners:

> to inform his or her patients about their disease and its management, and to allow them to make those significant choices required where the disease affects the course of life and career.[53]

Moreover, they argue that patients:

> will not be appropriately helped unless their autonomy is fully respected, and this entails improving their capacity for making choices by the provision of full information, and honouring their trust in the profession by maintaining standards of confidentiality and truthfulness.[54]

Berglund also attends to autonomy.

> The principle of '*respect* for persons' otherwise known as the principle of autonomy, is about respecting the *wishes* and *dignity* of each person (emphasis in original).[55]

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[51] *Op cit,* p.59.
[52] Campbell, A. Charlesworth, M. Gillett, G. Jones, G. *Medical ethics,* 2nd edn, Oxford University Press, Auckland, 1997.
[53] *Ibid,* p.9.
[54] *Ibid,* p.28.
[55] Berglund, *op cit,* p.62. The idea that respect for persons is the same as respect for autonomy is contentious and problematic. See for example Little, M. *Humane Medicine,* Cambridge University Press, Cambridge, 1995 particularly chapters 6 & 9.

Seedhouse considers autonomy in his ethical framework. Seedhouse's notion of autonomy is rather complex. He argues for the primacy of autonomy in bioethics because health work's *raison d'être* is to enhance potential, or, to put it another way, to maximise or even create autonomy. This idea differs from the usual way autonomy is understood as respect for autonomy. For Seedhouse the concept is conceived as:

> a basic quality essential to human dignity, which can be enhanced or diminished dependent upon what happens to or is done to people... [Seedhouse goes on to argue that any work which increases autonomy] becomes work to raise the level of human possibility.[56]

After establishing the importance of autonomy to health work, Seedhouse then ranks autonomy. He argues that creating agency has priority over respecting autonomy. Once agency has been created then respecting autonomy takes primacy, however if respecting autonomy is not in the public interest then it may be overridden. Isolating patients with Severe Acute Respiratory syndrome for the public good would be an example of this.

Thompson, Melia and Boyd[57] also discuss the importance of autonomy. They argue that this principle is best understood as the duty to respect the rights and dignity of others. Thus respecting autonomy will promote a patient's well being. Thompson *et al* argue that autonomy gives rise to the duties of truthfulness, honesty and sincerity. In this they differ from Beauchamp and Childress who consider Thompson *et al's* duties as virtues.

Respect for autonomy underpins the ethical concept of informed consent, or in Australia, valid consent. Patients must consent, explicitly or tacitly, to all health care

[56] Seedhouse, *op cit,* p.182
[57] Thompson, IE. Melia, KM. Boyd, KM. *Nursing Ethics,* 4th edn, Churchill Livingstone, London, 2000.

treatment, providing they have the capacity to do so. Consent is valid if it satisfies the components of consent: competence, disclosure, understanding and voluntariness. Kerridge *et al*[58] include a discussion of competence in their analysis of consent. They argue assessing competence is a necessary skill for health care professionals. Wrong or inaccurate assessment can lead to a violation of the principles of autonomy and beneficence. The discussion of consent recognises the importance of the process to the autonomous choices of competent patients and for protection of incompetent and non-competent patients.

A different perspective on autonomy obligations is provided by Draper and Sorrell.[59] They argue that the discussion about the ethical obligations of doctors and, it could be argued other health care professionals, has been one-sided.

> Traditionally, medical ethics has asserted that, as autonomous agents, competent patients must be allowed to decide for themselves the course of their medical treatment, and even whether to be treated at all... Little or nothing is said about what kinds of decisions patients *ought* to make. Nor is much said about their responsibilities for making good rather than bad decisions (emphasis in original).[60]

They go on to argue that patients ought to be responsible for their own health, providing they are autonomous. And, moreover, arguments that hold that doctors and the medical profession must be captive helpers are problematic. Captive help is explained as an obligation to treat patients irrespective of whether they make good or bad health care decisions. Because autonomous patients have responsibilities to doctors which include their general moral obligations as citizens, and particular obligations as citizens of a welfare state who receive captive help, doctors have the

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[58] Kerridge *et al, op cit.*
[59] Draper, H. Sorell, T. Patients' responsibilities in medical ethics in Chadwick, R. Kuhse, H. Landman, WA. Schűklenk, U. Singer, P. (eds) *The bioethics reader: editors' choice,* Blackwell, Malden, 2007.
[60] *Ibid,* p.75.

right to refuse to treat patients who do not take responsibility for their health. There is one exception. If patients are critically ill they must be treated. The position that doctors can refuse to treat some patients is an interesting one. Can doctors refuse to care for patients who refuse to honour their general or specific obligations as citizens? Draper and Sorell offer two examples on this point. The first is a case in which a medically recalcitrant patient is refusing to limit their fluid intake even though they have renal failure requiring haemodialysis. Draper and Sorell argue that the doctor ought to give the patient an ultimatum after ensuring they understand the implications of their actions. This, they argue, will require the patient to be truly autonomous and responsible for their actions. However, if the patient is admitted to accident and emergency in heart failure, the doctor must treat them. They argue the safety net of captivity compels doctors to act in this case. The second example is of a patient who is unjustifiably and persistently rude or violent to their doctor. Traditional medical ethics, in this case, would allow this doctor to refuse to treat their abusive patient as would Draper and Sorell. Where they part from the traditional view is that they suggest that if the patient is consistently rude or violent to other doctors then it is not unethical if the medical profession denies the patient any meaningful doctor-patient relationship and only provides the patient with basic care at a hospital (in accident and emergency) and, if necessary, under guard.[61]

While there is no legal obligation to treat patients except in emergency situations, there is arguably an ethical and professional obligation to treat patients who appear not to take responsibility for their own health, given that a failure to do this is very

[61] *Ibid*, p.89.

common, and, in many cases, a part of the whole picture which the doctor shout take into account if managing patients in a holistic way.

2.3.2.3 Ethical Principles – Non-Maleficence

The next principle analysed by Beauchamp and Childress is non-maleficence: the Hippocratic principle *"primum non nocere"* or do no harm. Do no harm, Beauchamp and Childress maintain, requires health care professionals to intentionally refrain from harming others, and they consider it generally more stringent than the principle of beneficence. The principle of non-maleficence is expressed in health care professionals' legal duty of care and concepts of professional negligence. Beauchamp and Childress argue discussion of end of life issues, particularly those surrounding killing and letting die, inevitably involve the principle of non-maleficence.

Hippocratic principles also feature in Campbell *et al.* They reject Kantianism and Utilitarianism as the sole foundations for medical ethics and instead suggest an alternative suitable grounding, the genesis of which is to be found in Hippocrates. The first Hippocratic concern was aimed at physicians:

> to set apart those individuals prepared to submit to the discipline and standards of medicine.[62]

Campbell *et al* argue that this moral and professional standard ought to be broadened to include adherence to appropriate scientific and clinical standards. The second provision of the Hippocratic Oath is for doctors to act in their patients' best interests and to refrain from harming them.

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[62]Campbell *et al*, *op cit*, p.8.

2.3.2.4 Ethical Principles - Beneficence

The third principle that Beauchamp and Childress discuss is the principle of beneficence or doing good. This refers to the moral obligation to act for the benefit of others. The authors show how this principle plays a pivotal role in common-morality theories and Utilitarianism, where beneficence is expressed as utility. Beauchamp and Childress include discussion of paternalism with reference to beneficence. They use the following definition of paternalism:

> the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden.[63]

They argue that historically the principles of beneficence and non-maleficence have been used by the medical profession to justify paternalistic actions towards patients. They also argue that beneficence does occasionally provide reasons for justifiable paternalism.

2.3.2.5 Ethical Principles - Justice

The principle of justice is discussed in terms of both micro- and macro-allocation and from various standard theories and approaches. Beauchamp and Childress conclude that issues surrounding the delivery of just health care are of huge social importance. Indeed it has occupied much of the space in bioethics journals which I referred to at the start of this chapter. Beauchamp and Childress strongly argue for an enforceable right to a decent minimum standard of health care: their position is grounded in two arguments. The first is the argument for social protection – health care is similar to

[63] Beauchamp and Childress, *op cit,* p.178.

other essential services provided by Governments – and therefore Governments are expected to counteract bad luck from the social or genetic lotteries. Thus:

> [I]nsofar as injury, disability, or disease creates profoundly significant disadvantages and reduces agents' capacity to function properly, justice requires that we use societal health care resources to counter these effects and to restore to persons a fair chance to use their capacities.[64]

The second argument is an appeal to the fair opportunity rule, following Daniels.[65] Beauchamp and Childress do discuss the ongoing debate over whether rights to health care can be forfeited. While antisocial behaviour including criminal activity is mentioned in passing, the discussion centres upon whether society ought to limit or exclude health care to those who voluntarily take risks injurious to their health.

As with Beauchamp and Childress, Kerridge *et al* discuss both macro- and micro-allocation issues, including rights based arguments, funding and funding mechanisms, and equity. Equity is defined as fairness and is closely tied to the principle of justice. Following Sen[66] they argue:

> equity is ultimately concerned with both issues of fairness and justice within wider social arrangements, particularly with the distribution of wealth and power, and with the role that health, in turn, plays in human life and freedom.[67]

2.3.2.6 Moral Rules

Over and above the general moral principles relevant to health care discussed above are, Beauchamp and Childress maintain, specific *prima facie* moral rules which arise from the health care professional-patient relationship. These include veracity, privacy, confidentiality and fidelity. Veracity refers both to the level and type of

[64] *Ibid, p.243.*
[65] *Ibid,* p.242-3.
[66] Sen, A. Why health equality *Health Economics,* 11, 2002, pp.659-66.
[67] Kerridge *et al*, *op cit,* p.546.

information provided to patients and that it is given in a way that fosters the patients' understanding. The moral obligation to tell the truth in the health care setting is reciprocal.

> By entering into a relationship in therapy or research, the patient or subject enters into a contract or covenant that includes a right to the truth regarding diagnosis, prognosis, procedures, and the like, just as the professional gains a right to truthful disclosures from patients and subjects.[68]

Kant[69] argues the truth must always be told irrespective of the consequences of telling the truth and whether or not it is expedient. He grounds truthfulness in the unconditional command of reason. Kerridge *et al* argue veracity derives from autonomy. They argue, however, that while this rule is important and professionals have an obligation to be truthful, this may be modified by taking account of the inherently unequal relationship between professional and patient. "Patients require truth but also need care, understanding and support, when facing illness or death."[70]

Collins, however, provides a different view. He argues that physicians are obligated to treat their patients with justice, graciousness and benignity; this, however, means that they must lie to them. Indeed "every physician should cultivate lying as a great art."[71] Collins's clear view that truth-telling is not beneficent arises from his experience with caring for patients over many years. Higgs[72] takes a position which is closer to Kant. Higgs does, however, admit there are some circumstances in which it is morally permissible not to tell the truth. His argument in favour of truth telling to patients is also grounded in respect for autonomy.

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[68] Beauchamp and Childress, *Op cit,* p.284.
[69] Kant, I. On a supposed right to lie from altruistic motives, in Chadwick *et al*, *op cit,* pp.499-500.
[70] Kerridge *et al, Op cit,* p.165.
[71] Collins, J. Should doctors tell the truth? in Kuhse, H. Singer, P. *op cit* p.502.
[72] Higgs, R. On telling patients the truth, in *Ibid,* pp.507-512.

The right to privacy, as with veracity, Beauchamp and Childress argue, is grounded in the principle to respect autonomy. Therefore "we respect persons by respecting their autonomous wishes not to be observed, touched, or intruded upon."[73] Patients exercise their right to privacy by granting health care professionals access to their bodies, thoughts, emotions, information and so on. The right to privacy also allows us to exclude others from access to these things.

Beauchamp and Childress argue that confidentiality refers to the provision of information on the understanding, either explicit or implicit, that the information will not be disclosed to another party without permission. "By definition, confidential information is both private and voluntarily imparted in confidence and trust."[74] Beauchamp and Childress recognise the historical importance of confidentiality to medical practice. It appears in the Hippocratic Oath and is central to codes of medical and nursing ethics for the very reason that health care practice requires that patients disclose relevant private and often sensitive information.

Confidentiality may be overridden in some cases. Indeed Beauchamp and Childress argue not only is it sometimes permissible to override confidentiality, it is obligatory. They argue that in cases where there is a high probability of major harm to other parties then confidentiality must be overridden, and cite the need to disclose HIV infection to third parties, specifically the unknowing spouses and lovers of HIV infected patients.

[73] Beauchamp and Childress, *op cit,* p.296.
[74] *Ibid,* p.306.

Kerridge *et al* define confidentiality as "to trust wholly or to impart knowledge with reliance upon secrecy."[75] They note the cultural and legal importance of confidentiality to societies which value autonomy and individual liberty. Kerridge *et al* maintain respect for confidentiality is grounded in the various approaches to ethics and can be defended by principle-based approaches, virtue ethics, and consequentialist arguments and for communitarian reasons. As for Beauchamp and Childress, Kerridge *et al* maintain the *prima facie* status of confidentiality. It can be overridden for reasons which include mandatory reporting of blood alcohol levels, domestic violence and, in some instances, for the greater good.

Berglund maintains privacy and confidentiality are considered key values and of great importance in the practitioner-patient relationship, primarily for the reasons of non-maleficence and duty of care. Thus confidentiality:

> should be maintained because otherwise there is the potential for harm to be done to the client, which would contravene their health care worker's duty of care to the client.[76]

Obligations of fidelity involve acting in good faith, and being trustworthy and loyal. Indeed Beauchamp and Childress argue the professional-patient relationship is founded on trust and confidence, with the health care professional entrusted with the patient's medical welfare.[77]

The issue of divided loyalties is discussed as conflicts of fidelity. Beauchamp and Childress argue the traditional view of the primacy of patients' interests is rendered complex by the delivery of modern health care and its social context. Divided loyalties or conflicts of fidelity may occur in the case of third party interests such as

[75] Kerridge *et al, op cit* p.237.
[76] Berglund, *op cit,* p.98.
[77] Beauchamp and Childress, *op cit,* p.312.

reporting suspected child abuse by an adult patient and institutional interests, for example medical examinations for employment or insurance. Nurses, they argue are especially open to morally problematic conflicts of fidelity which include, for example, conflicting obligations to doctors, institutions, other nurses, and their patients.

Beauchamp and Childress, then, defend four foundational action-guiding moral principles together with moral rules, as well as other-regarding moral virtues and attitudes as the basis of health care and the professional-patient relationship.

Many of the other authors cited above provide moral frameworks other than principlism. Campbell *et al* ground the foundations of ethics in Hippocratic ideals which include having appropriate skills oriented towards benefiting people, respecting persons with special regard for involving them in decisions, providing and ensuring an appropriate standard of health care and, finally, acting with justice and impartiality towards all patients. The doctors' inculcation of professional standards implicit in the role of medicine, beneficent action and the patient's autonomy, understood as leading a self defined worthwhile life, make up only part of the ethical story. Campbell *et al* argue certain moral principles assist in problem solving in medicine. These principles are non-maleficence and beneficence, professional integrity and justice. While accepting the need for consideration of the ethical principles, Campbell *et al* also note that without a primary principle or an underlying ethos, the principles in and of themselves are insufficient. They propose that the underlying ethos ought to be:

> the realisation that we are all reasoning and social creatures who have in common certain biological and psychological needs and vulnerabilities, and

> that, on the basis of the commitment and relationships that bind us together, we should care for one another.[78]

Johnstone[79] argues nursing ethics, or bioethics, is distinct from medical ethics/bioethics and health care ethics/bioethics. Ethical exceptionalism, according to Johnstone, is grounded in the unique perspective of nursing theory and practice. It is essentially ethical "*inquiry from the point of view of nurses' experiences*" (emphasis in original).[80]

The moral importance of the nurse-patient and professional-client, relationship is not discussed at length. Johnstone, however, maintains that the components of a respectful relationship must contain the following:

- acknowledgment of the moral worth and dignity of human beings;
- an unconditional positive regard and valuing of persons for *who they are* as moral beings;
- focussed attention on persons;
- empathically attuned listening (taking seriously what another says and knows);
- supportive actions aimed at promoting another's moral interests and wellbeing; and
- strategies aimed at 'saving face' and preserving the web of relationships (emphasis in original).[81]

Following Pellegrino,[82] Johnstone also maintains virtues are central to the therapeutic practitioner-patient relationship.

> (For example, of care, compassion, empathy, presence) ... are generally recognised as being both essential to and constitutive of a *healing* health professional-client (nurse-patient) relationship (emphasis in original).[83]

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[78] Campbell *et al, op cit,* p.12.
[79] Johnstone, MJ. *Bioethics: a nursing perspective,* 4th edn, Saunders, Marrickville, 2006.
[80] *Ibid,* p.14.
[81] *Ibid,* p.169.
[82] Pellegrino, E. Toward a virtue-based normative ethics for the health professions, *Kennedy Institute of Ethics Journal,* 5:3, 1995, pp.253-77.
[83] Johnstone. , MJ. *Bioethics: a nursing perspective,* 3rd edn, Saunders, Marrickville, 1999, p.134.

2.3.2.7 Rights

The rights based approach to health care ethics is another way of understanding the obligations of health care professionals to individual patients and, to a lesser extent society, and the crucial professional-patient relationship. Annas[84] defines a right as an enforceable claim. He argues patients have health care rights and these are the cornerstone of all humane and responsive health care systems.[85] Moreover, the right to health care is proclaimed, as we have seen, by both the United Nations and the World Health Organisation. Apart from the right to health care, Annas argues patients have five core rights. These are:

- The right to make informed decisions
- The right to privacy and dignity
- The right to refuse treatment
- The right to emergency care
- The right to an advocate.[86]

The BMA[87] outlines the ethical principles they claim are both widely accepted and of primary importance. They include beneficence, non-maleficence, autonomy, confidentiality and justice. They also assert the importance of regulatory mechanisms to ensure doctors conform to the profession's standards of best practice.[88]

Apart from setting out the moral principles which underpin medical practice they also outline the nine basic core values, representative of the enduring values of the medical profession. These are:

- Commitment

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[84] Annas, GJ. *The rights of patients: the authoritative American Civil Liberties Union guide to the rights of patients,* 3rd edn, Southern Illinois University Press, Carbondale, 2004.
[85] *Ibid,* p.11.
[86] *Ibid,* p.19.
[87] The British Medical Association *The Medical Profession & human Rights Handbook for a changing agenda,* Zed Books, London, 2001.
[88] *Ibid,* p.9.

- Caring
- Compassion
- Integrity
- Competence
- Spirit of enquiry
- Confidentiality
- Responsibility
- Advocacy.[89]

The BMA argue that there are compelling reasons for accepting the universality and indivisibility of human rights. They also argue the scope of ethical practice can be broadened by adopting human rights standards, particularly in the area of health policy and advocacy. Thus the combination of medical ethics and rights approach will lead to better care of patients by doctors.

The BMA addresses the role of doctors in contexts where human rights abuses do or can take place. The discussion of the obligations of doctors working in prisons, from a human rights perspective, is of most interest for this work.

The BMA argues that a wide range of human rights abuses occur in prisons, in both developing and developed countries. They note that many of the abuses that occur in prisons also occur in other places of detention, such as police stations. What is unique to prisons, however, "is that prisons provide for long-term incarceration and potentially lengthy involvement in a prisoner's health care."[90] Therefore, the provision of quality health care is a pivotal issue for doctors and, it could be argued, all health care professionals working in prisons.

[89] *Ibid,* p.10.
[90] *Ibid,* p.98.

Lack of adequate resources is an ethical and practical problem for many clinicians working in prisons, and this is particularly true for those working in developing countries. The problem of lack of health care resources, though, is not confined to poor nations. Moreover, the BMA report that prison clinicians feel professionally isolated because they lack support from the health care system, as well as from other health care professionals who are often reluctant to treat prisoners.

> Prison doctors, therefore, often have little support in responding to the complex health needs of prisoners, who, as a population, are notoriously unhealthy and also often have a multiplicity of other problems.[91]

The BMA maintain prisons themselves can cause health problems. Overcrowding and poor hygiene are obvious examples of environmental factors which contribute to the spread of infectious diseases. The BMA report describes how lack of cooperation (or active hostility) from prison authorities can be problematic for prison doctors. This is problematic in terms of unacceptable restrictions on clinical independence and their ability to provide the best care for their patients.

The issue of dual loyalties is raised. In countries where prison doctors are employed by the custodial authorities, doctors face the problem of being clinically responsible for their patient and managing resources appropriately. Doctors have reported incidents where undue pressure has been placed on them to not send patients out for specialist health services, because prison authorities refuse to allow an officer to accompany the patient. The BMA argues:

> [T]he clinician responsible for the patient's management should have independence, as far as is practically possible, in deciding the patient's care, although in practice clinical autonomy is not absolute. Doctors are generally aware of resource limitations but are torn between the ethical obligation to provide standards of care equivalent to that in society at large and containing

[91] *Ibid,* p.99.

costs in the treatment of a population for whom the public often had little sympathy.[92]

Patient confidentiality is another ethical issue raised in prisons. The BMA assert that patient confidentiality is difficult to maintain in prisons. They argue that medical records ought to be confidential and not accessed by custodial staff unless the patient gives their permission. They also support the view of the European Committee for the Prevention of Torture that "all medical examinations should be conducted out of the hearing and sight of prison officers unless the doctor concerned requests otherwise in a particular case."[93]

The issue of the incarceration of mentally ill patients is discussed at some length in the text. They maintain prisons are inappropriate places for patients with a mental illness. Moreover, the use of restraints either as punishment, or during medical treatment, is inappropriate.

2.4 International Declarations

The United Nations *Universal Declaration of Human Rights*[94] sets out, in twenty five articles specific universal and inalienable human rights. Health and medical care is contained in Article 25. This declaration, however, does not specifically address the human rights of prisoners. This issue is addressed it the United Nations *Standard*

[92] *Ibid,* p.106.
[93] *Ibid,* p.111.
[94] United Nations *Universal Declaration of Human Rights,* Geneva, 1948. Available at http://www.un.org/Overview/righst.html. accessed 9.1.2008.

Minimum Rules for the Treatment of Prisoners (SMR). [95] Underpinning these rules is the ideal that all prisoners ought to be treated humanely and with respect. As Levy[96] points out the SMR renders prison medical officers not only responsible for the medical care of prisoners, but also for their humane care. Prison doctors are responsible for ensuring prisoners have adequate and appropriate food, clothing and bedding, for the hygiene and cleanliness of prisoners and environment, as well as the sanitation, heating, lighting and ventilation of the prison. Prison doctors are also responsible for ensuring the rules for exercise are adhered to.[97]

The United Nations also provides ethical guidance for health care practitioners working in prisons.[98] There are six principles which inform health care professionals working in prisons. Principles 1 and 5 are particularly relevant for this thesis. Principle 1 states that health care practitioners, particularly doctors:

> have a duty to provide [prisoners] with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Principle 5 states:

> [I]t is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners of detainees, or of his guardians, and presents no hazard to his physical or mental health.[99]

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[95] United Nations, *Standard Minimum Rules for the Treatment of Prisoners,* Geneva, 1955. Available at http://www.unhchr.ch/html/menu3/b/h_comp34.htm. Accessed 3.5.2006.
[96] Levy, M. Prisoner's right to health and safety, Brown, DL. Wilkie, M. (eds) Prisoners as citizens: human rights in Australian prisons, The Federation Press, Sydney, 2002, Chapter 14.
[97] United Nations, *Standard Minimum Rules for the Treatment of Prisoners,* Geneva, 1955, p.5.
[98] Office of the United Nations High Commissioner of Human Rights, *Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment,* Geneva, 1982. Available online at http://www2.ohchr.org/english/law/medicalethics.htm. accessed on 9.1.2008.
[99] *Ibid.*

The document maintains that it is contrary to medical ethics for heath care practitioners to engage in torture or inhumane punishment (Principle 2); to have a relationship with prisoners other than a professional one (Principle 3); to be involved in interrogation or punishment of prisoners which is not in accordance with relevant international instruments (Principle 4); and that these principles are binding, even in a public emergency (Principle 6).

2.5 Codes of Ethics

The AMA's Code of Ethics grounds doctors' ethical responsibilities in the expertise of doctors and their role in maintaining the health of patients. Central to this is the doctor-patient relationship. It is a partnership based on mutual respect and collaboration and mutual rights and responsibilities. Pivotal to the doctor-patient relationship are the principles and values of mutuality, respect, compassion, confidentiality, beneficence, and competence. The important issue of clinical independence is addressed in the code. The AMA considers clinical independence necessary for the delivery of high quality health care.

> Protect clinical independence as it is essential when choosing the best treatment for patients and defending their health needs against all who would deny or restrict necessary care... Recognise your right to refuse to carry out services which you consider to be professionally unethical, against your moral convictions, imposed on you for either administrative reasons of for financial gain or which you consider are not in the best interests of the patient.[100]

[100] The Australian Medical Association. *AMA Code of Ethics,* Editorially revised 2006. Available at http://www.ama.com.au/web.nsf/doc/WEEN-6VL8CP accessed 3.11.07.

The AMA has also produced a Position Statement on the health care of prisoners and detainees.[101] The opening statement affirms a prisoner's right to health care which must be provided in a fair and just manner.

> Prisoners and detainees have the same right to access, equity and quality of health care as the general population....
> Medical practitioners should not deny treatment to any prisoner or detainee on the basis of their culture, ethnicity, religion, political beliefs, gender, sexual orientation or the nature of their illness. The duty of medical practitioners to treat all patients professionally with respect for their human dignity and privacy applies equally to the care of those detained in prison, whether convicted or on remand, irrespective of the reason for their incarceration.[102]

But while asserting prisoners have rights to just health care, the document implicitly recognises this may be problematic.

> The provision of health care is potentially constrained due to the physical and social environment of correctional facilities. Prisoners and detainees may face particular health problems, both pre-existing and associated with incarceration, such as exposure to blood-born and sexually transmitted infections, inadequate provision of a broad range of harm-minimisation measures, and lack of access to health education programs.[103]

The document sets out the role of medical practitioners working in prisons and these include the ethical requirements to act in the patient's best interests, maintain patient confidentiality, not participate in inhumane treatment and importantly "base their medical judgments on the needs of their patients; these judgements should take priority over non-medical matters".[104]

The *Code of Ethics for Nurses in Australia*[105] sets out six value statements, each with concomitant explanatory statements.

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[101] The Australian Medical Association, *Health care of prisoners and detainees,* 1998. Available at http://www.ama.com.au/web.nsf/doc/SHED-5G4V6U. accessed 3.11.07.
[102] *Ibid,* p.1.
[103] *Ibid.*
[104] *Ibid.*
[105] Australian Nursing and Midwifery Council, *Code of Ethics for Nurses in Australia,* ANMC, Dickson, 2002.

1. Nurses respect individual's needs, values, culture and vulnerability in the provision of nursing care.
2. Nurses accept the rights of individuals to make informed choices in relation to their care.
3. Nurses promote and uphold the provision of quality nursing care for all people.
4. Nurses hold in confidence any information obtained in a professional capacity, use professional judgement where there is a need to share information for the therapeutic benefit and safety of a person and ensure that privacy is safeguarded.
5. Nurses fulfil the accountability and responsibility inherent in their roles.
6. Nurses value environmental ethics and a social, economic and ecologically sustainable environment that promotes health and well being.[106]

This code is very broad and consequently all of the ethical statements are of relevance to prison nursing. The Australian Nursing and Midwifery Council (ANMC) does not have any publications specifically on the heath care of prisoners, unlike the ICN. The ICN's *Nurses' role in the care of Detainees and Prisoners*[107] reaffirms the rights of all persons as stipulated in The United Nations *Universal Declaration of Human Rights* and other protocols.[108] Specifically it includes that prisoners have a right to humane health care, adequate information about their treatment, the right to refuse treatment and the right to die with dignity. The position paper states nurses ought to safeguard the rights of prisoners, not to assume the functions of prison security, and to ensure that all prisoners have the basic necessities for life.

The nurses and doctors working for CHS are bound by their professional codes and guidelines (ANMC and AMA codes respectively) as well as by professional, legal and ethical requirements specific to the prison environment. These are identified in the

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[106] *Ibid.*
[107] International Council of Nurses, *Nurses' role in the care of detainee and prisoners,* revised 2006. Available at http://www.icn.ch/psdetainees.htm. accessed 8.1.08.
[108] United Nations, *Universal Declaration of Human Rights*, 1948, *op cit*; United Nations, *Standard minimum rules for the treatment of prisoners,* 1955, *op cit.*

CHS document *Professional and Ethical Guidelines for Corrections Health Staff.*[109] This publication has been revised, and now includes the NSW Health code of conduct plus prison specific professional requirements. However, since the CHS document was current during the time this research was conducted, it is important to refer to the superseded document.

Professional and Ethical Guidelines aims to:

> act as a resource for practising staff in relation to their conduct and practice. This in turn will minimise or eliminate potential occurrences of unprofessional behaviour and the formation of inappropriate relationships with inmates/patients as well as ensure staff are trained and made aware of the challenges faced in the staff/inmate relationships in the correctional environment. [110]

The ethical obligations of CHS staff are based on the four principles outlined by Beauchamp and Childress and widely discussed in the bioethical literature. These are autonomy, justice, beneficence, and nonmaleficence.

The text also outlines professional obligations in terms of the elements and importance of the therapeutic relationship. The elements include:

- Establishing contact
- Engagement
- Empathy
- Genuineness
- Rapport
- Facilitating patient growth
- Non judgmental
- Acceptance
- Respect
- Caring

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[109] Corrections Health Service, *Professional and Ethical Guidelines for Corrections Health Staff,* 4th edn, 2000. This document has been superseded by Justice Health, *Code of Conduct,* 2006. Available online at http://www.justicehealth.nsw.gov.au/pubs/code_of_conduct_new.pdf. accessed 10.1.06.
[110] CHS, *op cit,* p.6.

> The patient should demonstrate verbal and non verbal evidence of liking and being responsive to the professional, a sense of relaxation and a sense of confidence in the relationship. The therapeutic tasks involve clarification, explanation, negotiation, with a view to enhancing the development of a working relationship.[111]

The importance of the therapeutic relationship, and possibly its moral basis though this is not articulated, is to assist patients in achieving their goals. Therapeutic or professional relationships are distinguished from personal relationships. Boundary violations include inappropriate sexual relationships, breaches of confidentiality, improper termination of therapy, abuse and dual relationships (personal or business relationships with patients).[112] The document also provides a series of questions so clinical staff can assess their vulnerability to professional misconduct/boundary violations. Professional risks and boundary issues are clearly important in the correctional context. To my knowledge, two nurses employed by CHS (now Justice Health (JH)) have been found in breach of their professional and ethical obligations for boundary violations by the New South Wales Nurses and Midwives Tribunal.[113] Information about how to deal with abusive patients and those who are non-compliant with treatment is also provided. Essentially, patients have a duty to behave in appropriate ways to clinic staff. If patients refuse to behave appropriately staff document the incident. If the patient's behaviour does not improve, a custodial officer will put the patient on report and, if appropriate, inform the Governor of the gaol and/or remove the patient from the clinic.

If patients demand non-medically indicated treatment or are non-compliant with a treatment, they must be advised of the reasons for treatment and the implications of

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[111] *Ibid,* p.8.
[112] *Ibid,* p.9.
[113] *Penfold* (Nurses Tribunal of New South Wales, 5 June 1996 and HCCC v Sunjic [2008] NSWNMT 12 cited in Health Care Complaints Commission v Sunjic, 2008

their non-compliance. This information is to be recorded in their clinical file. Non-compliance issues must be reported to senior staff members such as the Director of Clinical Services or the Chief Executive Officer.

The Code of Conduct and Ethics[114] articulates the core mission of (the now) JH and its compliance with NSW Health Department Policy. The organisation is committed to a duty of care to all patients, and that its operations will be carried out "efficiently, effectively, economically, fairly, impartially and with integrity."[115]

It contains rules about personal relationships with patients, conflicts of interests, the policy on receiving gifts, outside employment, political affiliations and participation, public comment, use of resources, security of official information, criminal record checking, corrupt conduct, occupational health and safety issues among others.

2.5.1 Core Competencies

Apart from codes of ethics, core competencies or capabilities have been identified by nurses working for NSW Justice Health (JH). These include a combination of skills, beliefs and attitudes "Justice Health nurses believed they were required to possess in order to practise safely in the correctional environment."[116] A self-report tool was developed to measure the level of competency of nursing staff. Nurses working in juvenile and adult correctional centres were invited to complete the tool. Although only 17.5% (n=83) of nurses working in adult women's and men's correctional centres responded to the survey, it is worth considering their responses, particularly to

[114] Justice Health, *The Code of Conduct and Ethics,* Revised 2000.
[115] *Ibid,* p.1.
[116] Cashin, A. Potter, E. The core capabilities of Justice Health nurses, NSW Justice Health, Sydney, 2007, p.2.

the section on Professional and Ethical competencies. The other sections measured nurse competencies or capabilities on management of care, enabling, and critical thinking and analysis.

It should be noted that the competencies were framed in terms of safety. According to the results, however, the section on professional and ethical practice was less problematic for respondents in that they were more likely to feel very capable in this area of practice. There was a greater spread of responses by the nurses surveyed about whether they had developed the core capabilities in the other important areas of practice. But what is clear is that the nurses surveyed were very confident about their competency to practise professionally and ethically.

2.6 *Ethics in Correctional Contexts*

In this section I will consider ethical issues identified in the literature as specific to correctional contexts. These include claims of exceptionalism, values tension, capital punishment and dual loyalties. I do not mean to imply these ethical issues occur only or exclusively in the correctional context: clearly they do not. The problem of dual loyalties, for example, can occur in other situations, such as hospitals. But the critical point is that the prison context renders issues such as dual loyalties more problematic. Claims of exceptionalism too occur in other circumstances usually about genetic technologies. Capital punishment is a genuinely unique experience to prisons.

2.6.1 Ethical and professional issues raised in the literature

Both database (Cinahl, Medline and Pubmed) and library searches elicited surprisingly little information on doctors and nurses working in the correctional context. Indeed, more information could be found relating to the experiences of correctional officers. Medical discussions in the professional journals tended to relate to the management of patients in prisons, particularly about transmission of infectious diseases,[117] mental health problems,[118] research,[119] gender,[120] and so on. Where ethical and professional issues were explicitly raised, the discussions, in the main, centred on the role of doctors in Nazi Germany and the lessons of Nuremberg,[121] and, more recently, the role of doctors in American military prisons, notably Guantanamo Bay and Abu Ghraib.[122] Texts and journal articles on forensic medicine and psychiatry were more likely to include discussion of ethical and professional issues for psychiatrists. These texts and articles considered such issues as dual loyalty,[123] reports for third parties,[124] Courts (eg. cavity searches,)[125] and killing for the state,[126]

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[117] Butler, TG. Dolan, KA. Ferson, MJ. McGuinness, LM. Brown, PR. Robertson, PW. Hepatitis B and C in New South Wales prisons: prevalence and risk factors, *The Medical Journal of Australia,* 166:127, 1997; Crofts, N. Stewart, T. Hearne, P. Ping, XY. Breschkin, AM. Locarnini, SA. Spread of bloodborne viruses among Australian prison entrants, *The British Medical Journal,* 310:6975, 1995.

[118] Tye, CS. Mullen, PE. Mental disorders in female prisoners, *Australian and New Zealand Journal of Psychiatry,* 40:3, 2006.

[119] Taborda, JGV. Arboleda-Flórez, J. Forensic psychiatry ethics: expert and clinical practices and research on prisoners, *Review Brazilian Psychiatry,* 28 (Supplement), 2006.

[120] Lewis, C. Treating incarcerated women: gender matters, *Psychiatric Clinics of North America,* 29:3, 2006.

[121] Vollmann J, Winau R. Informed consent in human experimentation before the Nuremberg code. *British Medical Journal,* 313:7070, 1996; Shuster, E. The Nuremberg Code: Hippocratic ethics and human rights. *Lancet.* 351:9107, 1998.; Katz J. The Nuremberg Code and the Nuremberg Trial. A reappraisal. *Journal of the American Medical Association,* 276:20, 1996; Lefor, AT .Scientific misconduct and unethical human experimentation: historic parallels and moral implications. *Nutrition.*, 21:7-8, 2005.

[122] Clark, P. Medical Ethics at Guantanamo Bay and Abu Ghraib: the problem of dual loyalty, *Journal of Law, Medicine and Ethics,* 34:3, 2006.

[123] O'Brien, KP. Pivotal issues in forensic psychiatry, *The Australian and New Zealand Journal of Psychiatry,* 32, 1998.

[124] Taborda, JGV. Arbleda-Flórez, J. Forensic Medicine in the next century: some ethical challenges, *International Journal of Offender Therapy and Comparative Criminology,* 43:2, 1999.

but also important, universal ethical issues pertaining to psychiatric care: equivalence,[127] autonomy and consent,[128] competence,[129] confidentiality,[130] and justice.[131]

There have been more studies and academic discussion of correctional nursing than medicine. This research tends to involve surveys, but mainly interviews, about the experiences of nurses in the correctional setting. While the research has clear ethical implications, it infrequently explores ethical issues. Like forensic medical texts, forensic nursing texts and journal articles include discussions about ethics and professional issues. Some of the issues discussed differ from medical concerns and include such things as dealing with risk and violence,[132] exceptionalism,[133] stress and burn out,[134] stress and satisfaction,[135] and, importantly, the tension between health and custodial concerns.[136] Other ethical concerns were similar to medicine: dual

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[125] Anno, BJ. Spencer, SS. Medical ethics and correctional health care, Puisis, M. (ed) *Clinical practice in correctional medicine,* Mosby, St Louis, 1998.
[126] Marks, JH. Doctors of Interrogation, *Hastings Center Report,* 35:4, 2005.
[127] Konrad, N. Arboleda-Flórez, J. Jager, AD. Naudts, K. Taborda, J. Tataru, N. Prison psychiatry, *International Journal of Prisoner Health,* 3:2, 2007; Birmingham, L. Wilson, S. Adshead, G. Prison Medicine: ethics and equivalence, *British Journal of Psychiatry,* 188, 2006.
[128] Roberts, LW. Informed consent and capacity for voluntarism, *The American Journal of Psychiatry,* 159:5, 2002.
[129] Taylor, RWM. Buchanan, A. Ethical problems in forensic psychiatry, *Current opinion in Psychiatry,* 11:6, 1998.
[130] Reams, PN. Smith, MN. Fletcher, J. Spencer, E. Making the case for bioethics in corrections, *Corrections Today,* April 1998.
[131] Weinstein, HC. Ethics in Security Hospitals, *Behavioural sciences and the Law,* 20, 2002;
[132] Crampton, R. How do nurses care for prisoner patients? Negative attitudes towards prisoner patients, and a range of moral and ethical conflicts, can make the caring role difficult for some nurses, *Kai Tiaki: Nursing New Zealand,* 13:3, 2007; Maeve, MK. Nursing practice with incarcerated women: caring with mandated isolation. *Issues in Mental Health Nursing,* 18, 1997.
[133] Weiskopf, CS. Nurses' experience of caring for inmate patients, *Journal of Advanced Nursing,* 49:4, 2005; Gadow, S. Restorative nursing: toward a philosophy of modern punishment, *Nursing Philosophy,* 4, 2003.
[134] Happell, B. Pinikahana, J. Martin, T. Stress and burnout in forensic psychiatric nursing, *Stress and Health,* 19, 2003.
[135] Flanagan, NA. Testing the relationship between job stress and satisfaction in correctional nurses, *Nursing Research,* 55:5, 2006
[136] Doyle, J. Clinical challenges that face nurses working in a correctional setting, *Contemporary Nurse,* 10, 2001.

loyalties,[137] autonomy and consent,[138] and killing for the state.[139] Professional isolation and marginalisation are also cited as problematic in the prison context. This is the case for both doctors and nurses. Holmwood and Rae state "[P]risons tend to be very isolated institutions"[140] and Doyle's research found that nurses also felt professionally isolated.[141] Gender issues relating to prisoners were discussed in the literature[142] however, there was little discussion of gender relations between clinicians working in prisons and between clinicians and custodial officers.

The problem of acculturation was also raised as an ethical issue in the literature. Acculturation is, in part, linked to professional isolation. Correctional facilities may be geographically remote, but also these facilities can only be accessed after strict security clearance procedures and with permission of the correctional authorities. Acculturation can occur because of organisational culture and influence. This was recognised in the Independent Commission Against Corruption Report (ICAC). [143]

The report states institutional dynamics are important because:

- The individual is likely to behave according to group norms even though they may go against what he or she would do outside of that group setting;

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[137] Holmes, D. Perron, A. Michaud, G. Nursing in corrections: lessons from France, *Global Forensic Nursing,* 3:3 & 4, 2007.
[138] Hayes, MO. Prisoner and autonomy: implications for the informed consent process with vulnerable populations, *Journal of Forensic Nursing,* 2:2, 2006.
[139] Holmes, D. Federman, C. Killing for the state: the darkest side of American nursing, *Nursing Inquiry,* 10:1, 2003.
[140] Holmwood, C. Rae, D. Prison Health: a different place for GPs, *Australian Family Physician,* 32:10, 2003, p.856.
[141] Doyle, J. Prisoners as patients: the experience of delivering mental health nursing care in an Australian prison, *Journal of Psychosocial Nursing and Mental Health Services,* 36:12, 1998, p.27.
[142] Sered S. Norton-Hawk, M. Disrupted lives, fragmented care: illness experience of criminalized women, *Women Health,* 48:1, 2008, Weiss, AM. Sekula, LK. Mothers behind bars: a call for research, *Journal of Forensic Nursing,* 4:2, 2008.
[143] Zipparo, L. *Ethics: the key to good management,* NSW Independent Commission Against Corruption, Sydney, 1998.

- Highly cohesive workgroups can be at risk of making unethical decisions unless led by managers who encourage the expression and consideration of diverse views;
- An unethical workforce will perpetuate itself because those staff with ethical standards in conflict with the organisation will leave.

Grant examines the role of prison specific institutional influences on correctional staff behaviour. She argues that the influence of organisations on behaviour is significant.

> While broader organisational structures and frameworks provide a context for ethical decision-making by organisational members, these processes can be overridden by especially strong attitudes of peer working groups. Because members share in common values, functional/operational working contexts and environments they may also frequently develop inter-group biases... The nature of the correctional environment can make this uniformity of biases, not just behaviour, seem essential to survive. As a result, correctional centres would appear to be one environment of adult socialisation in which the acculturation of values and biases takes precedence over adherence to behavioural norms...[144]

2.6.2 Values Tension

Prisons are institutions which have significant deprivation of individuals' liberty as their primary purpose. In this they differ from hospitals and schools: these restrict the liberty of patients and students in order to enable carers and teachers to achieve the goals of these institutions – therapeutic benefit and education, respectively. Thus, restriction of liberty is not their primary purpose; it is *instrumental for* achievement of the goals indicated. So, health carers who work in prisons see patients who have significantly less liberty than do patients and clients elsewhere; and they see them in a context which is structured precisely to give sustained expression to this lack of liberty. As Watson, Stimpson and Hostick argue:

[144] Grant, A. Ethics and the role of the correctional officer, O'Toole, S. Eyland, S. (eds) *Corrections criminology,* Hawkins Press, Sydney, 2005, p.196.

> [P]risons are not, primarily, concerned with the health of the prison population and, indeed, "[T]he need for security and discipline can cut across the perception of individuals (prisoners) as patients".[145]

The tension between the goals of health care and those of security was raised by a number of international nursing scholars. Research in the United States of America, Great Britain, Canada, Australia, France and South Africa found ideological conflict or values tension between the goals of security or custody and health and nursing. Gadow argues imprisonment causes deliberate harm, and the purpose of health care aims to prevent it. She maintains that conflicts between acting in the patient's best interests and institutional goals are inevitable:

> [T]he ethical conflict between health care and correctional systems... is intrinsic. Correctional systems exist in order to punish, that is, to harm. Health professionals practise for the opposite reason, to promote well-being. The premise of care, acting for the good of patients, contradicts the calculated causing of harm... prison health care can be described as oppositional practice. It is oppositional not because it tries to overthrow or undermine the correctional system, but because it accepts the system as a context for practice that is based on opposing values.[146]

Health care practice, according to the research discussed below, is not merely oppositional; health care is subordinated to custodial practices. Smith maintains nurses working in a correctional facility "enter a closed world where health care is no longer the priority, where their nursing may be viewed with suspicion and their activities may be severely restricted."[147] Weiskopf, in her study of nine Canadian registered nurses working in corrections, had similar results. Participants found negotiating the "strict boundaries set by the correctional system" frustrating and

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[145] Watson, R. Stimpson, A. Hostick, T. Prison health care: a review of the literature, *Nursing Studies,* 41, 2004, p.120. Cited in quotation marks, Her Majesty's Inspectorate for Prison for England and Wales, *The future organisation of prison health care*, London, 1996, p1.

[146] Gadow, *op cit,* p.162.

[147] Smith, S. Stepping through the looking glass: professional autonomy in correctional nursing, *Corrections Today,* 67:1, 2005, p.54.

created limits on how nurses could provide care.[148] Willmott too argues that "there is an inevitable incompatibility between custody and health care."[149] This finding was also mirrored in research by Dale and Woods[150] and Gulotta.[151]

Holmes makes a stronger claim. He argues nurses are "[not only] vested with the mission of providing psychiatric nursing care that is coupled, on a daily basis, with the mission of discipline which includes surveillance and punishment."[152]

2.6.3 Dual loyalties

Both medical and nursing researchers and scholars raise dual loyalty as an ethical issue in the prison context. Different authors refer to this problem by different names, so dual loyalties are also referred to as divided loyalties, boundary issues, and doctors and nurses as having dual roles, or being double agents. Dual loyalties are distinct from *conflicts of obligation*, which occur routinely in all professional practice because multiple relationships are the norm of professional life. Such conflicts obtain when a professional is subject to concurrent obligations – either from outside claims (eg. work and family) or internal claims (between two patients).[153] These conflicts may be resolved in a variety of ways: there may be an equitable resolution or it may be inevitable that one party will be disadvantaged. Providing such conflicts are resolved in the least harmful way, no special moral problem arise because, as Toulmin points

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[148] Weiskopf, o*p cit,* p.339.
[149] Willmott, Y. Prison nursing: the tension between custody and care, *British Journal of Nursing,* 6:6, 1997, p.333-4.
[150] Dale, C. Woods, P. *Caring for Prisoners,* Royal College of Nursing, London, 2001.
[151] Gulotta, K. Factors affecting nursing practice in a correctional health care setting, *Journal of Prison and Jail Health,* 6:1, 1986.
[152] Holmes, D. Governing the captives: forensic psychiatric nursing in corrections, *Perspectives in Psychiatric Care,* 41:1, 2005, p.4.
[153] Toulmin, S. Divided loyalties and ambiguous relationships, *Social Science and Medicine,* 23:8, 1986, p.783.

out, and as with the moral principles discussed earlier in this chapter, professional obligations are *prima facie.* Divided loyalties, however, occur "where the demands of the various relationships are *fully and generally* irreconcilable, because the continuing claims to which some of them expose us require us to *abjure* those of the others (emphasis in original)."[154]

Some of the medial and nursing literature on divided loyalties tends to elide or collapse the concepts of conflicts in obligation into divided loyalties. For example, the Dual Loyalty Working group defines dual loyalties as:

> a clinical role conflict between professional duties to a patient, and obligations, express or implied, real or perceived, to the interests of third party such as an employer, an insurer or the state.[155]

The above definition is ambiguous in that it could refer to conflicts of obligation or dual loyalties. For the purpose of this thesis dual loyalties will not refer to conflicts of obligation issues but irreconcilable differences which require the subversion of clinical obligations.

Solomon argues dual loyalties are unavoidable in clinical practice. These occur commonly in situations whereby public health laws require the mandatory reporting of communicable diseases by physicians or when hospitals, for financial reasons, control a physician's treatment choices. She argues though, that "the most ethically difficult dual-loyalty challenges occur when it is the state or the military exerting

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[154] *Ibid,* p.784.
[155] Dual Loyalty Working Group, *Dual Loyalty and Human Rights,* Physicians for Human Rights & School of Public Health and Primary Health Care, The University of Cape Town Health Sciences Faculty, USA, 2002, p.2.

pressure on healthcare professionals".[156] Murray maintains that dual loyalties are revealed in the social control functions of medicine. "One of the most disturbing results of divided loyalties dilemmas is the use of medicine to do the 'dirty work' for institutions, especially so when that social control work is dressed up in the trappings of a therapeutic enterprise.[157] Bloche too argues that the use of clinical skills to serve social ends unrelated to health generates controversy.[158]

In the literature on the correctional context, dual loyalties refer to the conflict between the best interests of inmate patients, and the state, and/or the criminal justice system. This issue is particularly relevant to forensic medicine and "especially evaluations of a forensic type such as competency to stand trial, insanity defence arrangements, and parole evaluations."[159]

Acculturation in the prison context involves health care professionals assuming and prioritising correctional values. Conflicting obligations, provided they are resolved in the least harmful way, may not pose any specific ethical problems. However, requiring health care professionals to adopt a security or discipline role as part of their health care practice as described by Holmes in the previous section, is an example of dual loyalties because the obligations to patients are abrogated to that of the custodial institution.

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[156] Solomon, MZ. Healthcare professionals and dual loyalty: technical proficiency is not enough, *Medscape General Medicine,* 7:3, 2005, p.15.
[157] Murray, TH. Divided loyalties for physicians: social context and moral problems, *Social Science and Medicine,* 23:8, 1986, p.828.
[158] Bloche, MG. Clinical loyalties and the social purposes of medicine, *Journal of the American Medical Association,* 281:3, 1999, p.269.
[159] Weinstein, *op cit,* p,448.

2.6.4 Exceptionalism

Exceptionalism – the idea that "phenomena raise unique ethical or legal issues"[160] is a feature of the nursing literature, particularly the forensic nursing literature, in the correctional context. Prison nursing is different it is claimed, for mainly two reasons: the unique environment and clinical specialisation. Weiskopf, for example, found

> The lived experience of delivering nursing care in the correctional setting can best be described as different from all other health care settings because of the strict boundaries set by the correctional system.[161]

Among others, Gulotta, Smith, Maeve, and Gadow,[162] argue that correctional nursing or correctional forensic nursing is unique because of some or all of the following: the patients, the environmental context, the requisite skills and knowledge, the complexity of care, the boundary issues, and the ideological tension.

2.7 Conclusion

State sanctioned coercion is the deprivation of liberty to ensure the stability and security of society. There is no disagreement, certainly amongst liberal theorists, over the legitimate use of coercion on grounds of *inter alia* harm to others. Rawls argues legitimate coercive agencies are grounded in the principle of liberty. Foucault and neo-Foucauldian scholars argue the deprivation of liberty is not the only purpose of imprisonment, they argue prisons also have a transformative function.

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[160] Lipworth, W. Generating a taxonomy of regulatory responses to emerging issues in biomedicine, *Journal of Bioethical Inquiry,* 2:3, 2005, p.130.

[161] Weiskopf, *op cit,* p.339. See also Gulotta, *op cit,* who argues the high level of job satisfaction was accounted for by uniqueness of setting and Lynch, V. Forensic aspects of health care: new roles, new responsibilities, *Journal of Psychosocial Nursing and Mental Health Services,* 31:11, 1993, who argues for unique epistemology,

[162] Gulotts, *op cit,* Smith, *op cit,* Maeve, MK. Nursing Practice with incarcerated women: caring with mandated isolation, *Issues in Mental Health Nursing,* 18, 1997, and Gadow, *op cit.*

It is clear from the brief summaries of various ethical/bioethical texts for medicine and nursing, anthologies, professional codes of ethics and universal declarations that while there are disagreements about ethics – which theoretical approach is best or, for example, whether lying is wrong or in the best interests of patients: there is great uniformity. General agreement has been reached on the issue of the moral basis of health care. It is generally agreed that health care is a moral good. Moreover, it is generally agreed that we ought to care for one another, particularly when we are ill or otherwise disadvantaged. There is general agreement that health care professionals ought to be competent and have the skills necessary to care for their patients. Consensus has been reached on some of the moral principles or values inherent in the provision of health care and pivotal to the health care professional-patient relationship. These include notions of a right to health care, respect for persons, respect for autonomy, justice expressed in terms of equality and equity, impartiality, beneficence, doing no harm, veracity, best interests, confidentiality and respecting privacy. Apposite character traits, or virtues, for health care professionals include honesty, integrity, trustworthiness, sensitivity and other-regarding sensibilities.

In the literature there is also an understanding that the health care professional-patient relationship is a reciprocal one. The reciprocity is not necessarily equal; indeed the majority of writers in this field argue the obligations are weighted heavily towards the health care professional. There is, however, recognition that the health care professional-patient relationship cannot function morally, or in practice, unless competent patients trust and are trustworthy, and take some responsibility for their health and for their health choices. Implicit in the relationship is the understanding

that patients will have similar health goals to their health care professionals. That is, both are working towards improving the health of patients and/or ameliorating the effects of disability and/or disease.

In the case of prisons, most authors argue and codes and declarations state that prisoners ought to be treated humanely and with respect and that their right to health care is not diminished or extinguished by incarceration. There is general agreement that the health care professional-patient relationship ought not to be compromised by imprisonment; specifically, health care professionals ought not to be involved in torture, or any treatment which is not medically indicated. In other words, while context matters, health care ought to be privileged over security arrangements.

There is also recognition that health care professionals practising in prisons do face issues which are extremes of those faced in other contexts. Boundary issues are recognised as problematic by CHS in its text as well as by researchers in the field. The issue of exceptionalism, ideological tensions and the problem of dual loyalties appear in the literature. The AMA recognises that the provision of health care may be constrained by the prison context and that health care problems may arise as a direct result of incarceration. It is important to note here that while various authors and organisations recognise that health care work in prisons may be problematic for a variety of reasons, none suggest that the ethics appropriate to, and for, the health care context in general, are not appropriate to and for the prison context. Indeed it is because we can articulate general ethical standards for health care practice that we can recognise ethical problems in the prison context.

In the next chapter I will explore the concept and relevant theories of context, specifically those by Goffman and Foucault. I will also explore the prison system in NSW, DCS, CHS and the health of the prison population and review of the major findings of Government inquiries and Royal Commissions into the prison context.

Chapter Three: The Context

3.0 Synopsis

In the previous chapter I discussed the notion of health as a social and moral good and ethical and professional health care practice. In this chapter I will discuss concepts and theories relevant to prisons including the work of Goffman and, to a lesser extent, Foucault. I will then go on to discuss historical and contemporary Australian prisons by examining both the physical context including the role and function of the DCS and the organisational context of CHS. I will then discuss the social context of the prison population and their health problems. Finally, I will discuss government inquiries into health care provision in the NSW correctional context.

3.1 The Concept of Context

The term context originated from weaving. It literally means "woven or knit together."[1] Burke,[2] in a wide ranging and thorough analysis of context, traces its meaning/s historically and across disciplines. He argues the uses and denotations of context have evolved and expanded – so that it now has a range of meanings and is used in different ways by different disciplines. The several meanings of context date back to Augustine who used context to mean a literal or contextual reading (of the bible). It was also used to denote circumstance and coherence. While the earlier uses were retained, in the sixteenth and seventeenth centuries and across all the main

[1] Little, W. Fouler, H. Coulson, J. & revised and edited by Onions, C. *The Shorter Oxford Dictionary on Historical Principles,* The Clarendon Press, Oxford, 1964, p.381.
[2] Burke, P. Context in context *Common Knowledge,* 8:1, 2002.

European languages, the term came to refer to the relationships between words and importantly, scope or "concern with intention or purpose."[3] The counter-enlightenment period saw the meaning of context again expand from text to include history, as in the historical context, and to the cultural context. This notion of context included local circumstances of a culture, and the entire culture, society or age.[4] The concept of context as the moral context was broadened to also include the historical and cultural context. In the early twentieth century the disciplines broadly understood as the humanities construed context in terms of situation.[5] Thus notions of the local situation, situational psychology, the context of situation, and situated knowledge found their way into the academic literature. Science too embraced context with journals and text appearing with context in the titles.[6] Burke shows how context replaced other terms such as circumstance, situation, occasion and scope. He also points out that context now includes such notions as contextualise, contextualism, decontextualise and recontextualise. I do not wish to enter the debate about the benefits and problems of the term context; it is enough to note that there are many contexts of context. For the purpose of this thesis the prison context will mean social, organisational and physical aspects necessary to and for punishing certain persons by depriving them of their liberty, protecting society from such people and transforming or correcting criminal behaviour/s.

[3] *Ibid*, p.155.
[4] *Ibid*, p.158.
[5] *Ibid*, p.160.
[6] *Ibid*, p.170.

3.2 Theories of the Prison Context

The insights and analysis from Erving Goffman and Michel Foucault are influential in any discussion of prisons. Hacking[7] argues that the works of Goffman and Foucault are not only important they are complementary. Hacking has a specific project in mind, a philosophical reflection on classifications of people and the people classified or, in Hacking's terms, making up people. Hacking's project is not the concern of this work, however his argument, that Foucauldian abstraction of social discourse and Goffmanian specificity of individual relationships are important for understanding total institutions, is.

According to Hacking, the spinning together of the discourses of Foucault and Goffman, is necessary for a thorough and appropriately complex understanding of people. First, they both recognise the need to view the making of people in what Hacking describes as extreme situations – the prison, the clinic, the asylum. Foucault does this by concentrating on disciplinary structures and how these institutions not only shape behaviour but give rise to new behaviours. He does not, however, explain in any detail the lives of these people. Goffman, while interested in the same project, immerses himself in the minutia of everyday life of those in such institutions and how people are shaped and changed by the institution, how new selves arise as a consequence of institutionalisation, and how the institutions are changed and shaped by the people in them.[8]

[7] Hacking, I. Between Michel Foucault and Erving Goffman: between discourse in the abstract and face-to-face interaction. *Economy and Society* 33:3, 2004.
[8] *Ibid.*

In the following section I will explore the relevant work of Erving Goffman and Michel Foucault. I will concentrate on the work of Goffman as his insights are more pertinent to this qualitative study of doctors and nurses working in women's prisons. Before discussing Goffman's notion of total institutions I will outline definitions of institutions.

3.2.1 Institutions

'Institution' is a complex concept and refers to "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."[9] An institution, therefore, denotes a physical site – buildings, walls, and barbed wire as well as the organisation *in situ* which 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 is a formal arrangement and 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 which make up the fabric of society and provide important social and cultural norms, which are enforced by law.

Prisons, as institutions, are buildings, organisations and structures which shape and determine behaviour by means of formal rules and customs. Meyer and Rowan argue institutions involve normative obligations and moreover, "involve processes,

[9] Hanks, P. (ed) *Collins Dictionary of the English Language*, Sydney, Collins, 1979, p.757.

obligations, or actualities... [that] take on rule like status in social thought and action."[10] Using the example of a doctor they explain

> the social status of a doctor is a highly institutionalized rule (both normative and cognitive) for managing illness as well as a social role made up of particular behaviors [sic], relations and expectations.[11]

3.2.2 Total Institutions

Erving Goffman's *Asylums*[12] is the result of his field work at St. Elizabeth's Hospital, Washington DC in 1955-56. Goffman's project was an ethnographic study of the social world of the psychiatric patient, particularly from their perspective. He argues that such groups, including prisoners, "develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it."[13] To this end he spent twelve months observing the day-to-day experiences of inmates. In this endeavour Goffman's ability to observe and then interpret the rich and nuanced experiences of inmates is illuminating. The research is, as Manning notes, "a passionate and sensitive portrayal of people whose every moment is monitored and judged."[14]

Goffman's ethnography led him to the notion of total institutions.

> A total institution may be defined as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life. Prisons serve as a clear example...[15]

Total institutions are grouped into five categories based on their function:

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[10] Meyers, JW. Rowan, B. Institutionalised Organizations: Formal structure as myth and ceremony, *The American Journal of Sociology,* 83:2, 1977, p.341.
[11] *ibid.*
[12] Goffman, E. *Asylums, Essays on the social situation of mental patients and other inmates*, Anchor Books, New York, 1961.
[13] *Ibid,* p.x.
[14] Manning, P. *Erving Goffman and modern sociology,* Polity Press, Cambridge, 1992, p.106.
[15] Goffman, *op cit,* p.xiii

1. institutions established for the care "for persons felt to be both incapable and harmless", eg., the aged , blind, orphaned, indigent;
2. those established "for persons felt both incapable of looking after themselves and a threat to the community, albeit an unintended one", eg., mental hospitals, TB sanitaria, leprosaria;
3. those organised "to protect the community against what are felt to be intentional dangers to it, with the welfare of the persons thus sequestered not the immediate issue" eg., gaols, concentration camps, prisoner of war camps;
4. those established to enable pursuit of "some worklike task and justify themselves only on these instrumental grounds" eg., army barracks, ships, boarding schools, work camps; and
5. those designed as "retreats from the world even while often serving also as training stations for the religious" eg. abbeys, convents, monasteries.[16]

Goffman further argues that while not all the elements of total institutions are common to all groups, they do share common characteristics to an intense degree.

Total institutions differ from other institutions. The key difference is their 'encompassingness'. Goffman argues total institutions depart from the basic social arrangement in modern (and it could be argued, western) society in which "individuals ... sleep, play, and work in different places, with different co-participants, under different authorities, and without an over-all rational plan."[17] Total institutions in contrast serve to breakdown the barriers dividing the usual spheres of life. They do this in the following ways.

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[16] *Ibid,* pp.4-5.
[17] *Ibid,* p.6.

> First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aims of the institution.[18]

These are key features of total institutions and lead, Goffman argues, to the following implications. Firstly, surveillance is the key activity of the small group of personnel required to supervise the inmates. Secondly, the split between these two groups is further reinforced by the fact that while inmates stay in the institution, the supervisors work shifts, live outside the institution and are socially integrated with the world outside. Social mobility between the two strata is prescribed and necessarily restricted, as too is communication and knowledge. This leads to an environment in which both social strata view each other with hostility and via narrowly conceived stereotypical views.

Goffman maintains total institutions are incompatible with two pivotal institutions in modern life: work and family life. The work arrangements in total institutions differ in several ways. Outside total institutions, "the authority of the work place stops with the worker's receipt of a money payment."[19] Prisons differ; the work place authority extends to every part of prison life. Moreover, the motives or reasons why people work are different in prisons. Inmates have all their basic needs taken care of – food, accommodation and health care – so work takes on a different meaning and does not

[18] *Ibid.*
[19] *Ibid,* p.10.

"have the structural significance it has on the outside."[20] Family life suffers because enforced batch living - eating and sleeping at work – prohibits "meaningful domestic existence."[21]

According to Goffman, total institutions impact on the lives of inmates in quite destructive ways. Inmates arrive with a sense of themselves constituted and derived by their "home world - a way of life and a round of activities taken for granted until the point of admission to the institution."[22] The inmate's sense of self, their very identity, is made possible by stable social arrangements, and this is stripped away by the procedures of incarceration. Goffman's term is 'mortification of self.' A person's identity is stripped away by institutional practices which include the radical loss of freedom, removal from their social network, limiting or removing their personal possessions, their inability to maintain any privacy, and their loss of a sense of personal safety.

Total institutions mortify the self because they:

> disrupt or defile precisely those actions that in civil society have the role of attesting to the actor and those in his presence that he has some command over his world – that he is a person with 'adult' self-determination, autonomy and freedom of action.[23]

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."[24] Prisoners are never alone and always watched. Private and potentially embarrassing information about themselves is available to the prison staff. They can

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[20] *Ibid.*
[21] *Ibid,* p.11
[22] *Ibid,* p.12.
[23] *Ibid,* p.43.
[24] *Ibid,* p. 23.

be subjected to strip searches and medical examinations; 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 adds to the process of mortification.

A further and more insidious form of assault upon the self is termed looping. Goffman argues that usually when people must accept circumstances which assault their sense of self, they are able to resist in some manner. One example would be an employee failing to show signs of deference to an authoritarian employer. This is a form of self-protective behaviour in response to humiliating circumstances. Prisoners, however, cannot engage in this self-protective behaviour as this may be punished, thus "an agency that creates a defensive response on the part of an inmate takes this very response as the target of its next attack."[25] Indeed defensive responses can be seen as confirmation of deviant behaviour, so all behaviour is seen through the prism of reinforcing stereotypes.

These mortifications are officially rationalised by the institutions on other grounds. In the case of prisons, they are rationalised on the grounds of security concerns but also by the need to organise the "daily activity of a large number of persons in a restricted space with a small expenditure of resources."[26]

Goffman argues that total institutions attempt to rebuild their inmates' identities by a system of privileges. Stripped of their civilian identity by the institution, the reward

[25] *Ibid,* p.35-36.
[26] *Ibid,* p.47.

system "provides a framework for personal reorganization."[27] This is achieved by formal rules of conduct, rewards for being obedient and, when rules are broken, punishments. This usually takes the form of withdrawal of privileges, but also includes the extension of a prison sentence. Goffman notes the rewards and punishments are a mode of organisation specific to total institutions. Adults are not treated this way outside these institutions.

Goffman outlines *inter alia* three more important features of total institutions. He suggests institutional perspectives (1) shape and form inmate's identities in ways which involves 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 (emphasis in original).[28]

He also suggests that since the work of total institutions is (2) people-work and, as one of the aims of such work necessarily involves the humane treatment of people, then one of the goals of these institutions entails provision of humane technical services. He argues professionals are brought in to perform such services. His research led him to argue that these professionals, however, are likely to be 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."[29]

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[27] *Ibid*, p.48.
[28] *Ibid*, p.87
[29] *Ibid*, p.92.

Goffman talks about the (3) permeability of institutions: that is, the degree to which social standards are evident inside the institution and visa versa. Goffman notes total institutions are particularly impermeable. Not only are they impermeable, they are particularly rigid. And their degree of totality constrains the ways in which the institution can be organised or reorganised.

Goffman argues the mortifying process of total institutions requires the inmate to adapt to differences between their home world and the institutional world. Goffman identified a four stage adaptation process.[30] The first stage is 'situational withdrawal' in which inmates withdraw into themselves. The second adaptation is intransigence. Inmates typically become uncooperative and difficult. The third adaptation is 'colonisation' in which the inmate recognises the desirability of their situation. The forth adaptation is 'conversion' in which the "inmate appears to take over the official or staff view of himself and tries to act out the role of the perfect inmate."[31] Goffman also argues that the home world of particular inmates may immunise him against "the bleak world on the inside, and for these persons no particular scheme of adaptation need be carried very far."[32]

In summary, Goffman's seminal study of total institutions is clearly important. His insights are significant for any discussions involving prisons. He meticulously detailed the lives of inmates who are constantly monitored and judged by their keepers. He also analysed how institutions organise and manage batches of inmates and how institutional practices work to break down and then re-establish the identities of those under their care. Indeed, Goffman argues this process is a mortification of

[30] *Ibid,* pp.62-63.
[31] *Ibid,* p.63.
[32] *Ibid,* p.65.

self in which the social structures and cultural artefacts necessary for maintaining a sense of identity are brutally peeled away. What is left is a person whose identity can be remade.

Goffman also argues total institutions differ from other institutions in crucial ways. Total institutions are encompassing in that individuals work, sleep, eat, and live in the one place. They are total in that there is no usual separation between these activities and places in which these activities normally occur. Inmates are treated as batches, in which individual differences are irrelevant. This is significantly different from other, non-total, institutions. The family institution, for example, is informally structured, separate from the workplace and a place in which individual differences are taken into account. Work, while highly bureaucratic, distinguishes between skilled and differentiated personnel. Non-total institutions are, in the main, less resistant to change. Goffman's work shows that the more total the institution, the more it "overrides attempts to change the purpose and ethos of a particular total institution.[33]

3.2.3 Total Institutions: Maximum and Minimum Security Prisons

Goffman's work *Asylums* has been criticised for substantive and methodological reasons.[34] The central problem with the concept, certainly from the perspective of this thesis, is that Goffman defined total institutions too loosely. He lumps, under the broad concept of total institutions, the military, boarding schools, mental asylums, monasteries and prisons. And it must be noted that even within the prison system,

[33] Davies, C. Goffman's concept of the total institutions: criticisms and revisions, *Human Studies,* 12, 1989, p.90.
[34] Manning, P. *op cit,* p.113.

some prisons are more total than others. For example, a maximum security prison sequesters and isolates prisoners in ways that do not obtain in a minimum security prison.

To understand the differences between the two types of prisons, I turn to the work of Christie Davies. Davies concludes that Goffman's concept of total institutions is not specific enough and, consequently, has been applied or adapted inappropriately in other studies.[35] He notes Goffman's total institutions are a feature of western modernity. Their defining characteristics include being enclosed, formally administered and subject to bureaucratic authority. Thus total institutions differ from other modern institutions – the family and corporations – whose authority is separated and differentiated.[36]

Davies concentrates his analysis of total institutions in three ways: on the degree of openness or closedness of institutions; the official purpose of institutions; and the main ways of eliciting compliance from inmates by staff.

He maintains some total institutions are more total than others. How total (or open/closed) an institution is depends upon two factors: voluntariness – did the inmates enter voluntarily and can they leave when they wish - and whether the institutional hierarchy is open. By that, Davies means whether the hierarchy can be crossed or whether there is a clear division of status between staff and inmates.

> In closed involuntary institution the inmates are forcibly... inducted and kept there against their will. From this fact stems the rigid, binary, divided hierarchy

[35] Davies, C. *op cit,* pp.77-95.
[36] *Ibid,* p. 80.

into staff and inmates that characterise them... Convicts do not become warders...[37]

Under this definition, both maximum and minimum security prisons are closed, that is, inmates are there involuntarily and the hierarchy is rigid. In contrast, members of a kibbutz, lumber camp and the merchant navy are, within reason, able to come and go as they please. Moreover, the hierarchy is open and the lines blurred. These can be described as open institutions. A middle category, located somewhere between open and closed institutions, would be monasteries. While the monks and nuns entered the institution freely, lifelong vows and institutional practices make leaving very difficult if not impossible.

Davies' second criterion of total institutions is their official purpose. He argues Goffman pays too little attention to the purposes of total institutions. Davies maintains there are three ways to classify total institutions by the purposes for which they were created. The first are institutions which are an end in themselves, created to isolate inmates from society; the second are those created for an external utilitarian function either economic or military; and, finally, those institutions whose task is to transform people, including educating, reforming, inculcating socially acceptable behaviours, and treating them. Prisons mainly fall into the last category.

The degree of openness or closedness of institutions, as well as the putative purpose of the institution, allows for more fine-grained understanding of important differences between institutions. Davis plots the degree of closure – closed, intermediate, and

[37] *Ibid,* p.86.

open – against the purpose. For example, ashrams are open institutions whose purpose is an end in itself, as are kibbutzim.

Prisons, Davies argues, can either stress containment or rehabilitation. As such, they have a mixed function. Prisons, particularly maximum security ones are closed and must serve the purpose of isolating prisoners from the wider community. However, their role also includes transmogrification in that they attempt to reform and educate prisoners. Minimum security prisons are less closed. These are not places where dangerous prisoners are incarcerated; therefore isolation is not such a compelling and encompassing function. Transmogrification is still a clear purpose – some minimum security prisoners are allowed to work outside the institution thus gaining skills requisite to living a fulfilling and lawful life on the outside.

Davies then adds another level of complexity to the analysis. Another dimension which ought to be considered in assessing how closed an organisation is the "dominant mode of compliance prevailing within the institution."[38] Compliance is influenced by the environment of the institution and includes social, economic and ideological influences. Modes of compliance, or rather how compliance is achieved, can be categorised, following Etzioni,[39] as coercive, normative or remunerative. If we think back to the examples used, ashrams, kibbutzim, lumber camps and the merchant navy were all open institutions whose inmates entered voluntarily. The purpose of the institutions differed however, with the purpose of the first two institutions ends in themselves, and the latter two with the purpose or function as an external task to perform. When we add the latest layer of analysis, we see ashrams and kibbutzim

[38] *Ibid.*
[39] Etzioni, A. A basis for comparative analysis of complex organisations, Etzioni, A (ed) *A sociological reader on complex organisations,* Hold, Reinhart and Winston, New York, 1961.

have a normative mode of compliance, whereas the merchant navy and lumber camps remunerative. Prisons, on the other hand, are closed institutions whose purpose is transmogrification/end in itself, and by which compliance is established by coercion.

This method of analysis allows us a systematic and more complex way to understand total institutions. It is noted by Davies that, the more open the institution, the less 'batch like' the inmates will be treated. The purpose of the institution also constrains the ways inmates can be treated. A voluntary, well paid sailor in the merchant navy will be treated in different ways to a psychiatric patient admitted involuntarily to the psychiatric ward. Differences can occur even within institutions. Highly skilled and differentiated personnel, army officers for example, will be treated differently to enlisted soldiers.

All prisoners are incarcerated involuntarily, and yet within the prison system there are differences in the level of closure and purpose between prisons. Prisons, usually those classified as minimum security, are more open than maximum security ones. Inmates, depending on their security classification, are allowed out on day release for work in the community and/or for further education. The reason for this is that these prisoners are less of a security risk, therefore there is not the same need to isolate them from the wider society; the prisons are less of an end in themselves. Moreover, more emphasis is placed on preparing the inmate for release. Thus prisoners leave the institution for short periods of time. While all prisons ensure compliance by coercion, minimum security prisons are less coercive. Conversely, in high security gaols the level of closure is extreme because the purpose of the institution is primarily one of security and protection of the wider community, and, after the fact, education and

rehabilitation. There is a high level of coercion. And the way compliance is established impacts upon the treatment of inmates. Davies argues:

> the humiliation and stripping away of an inmate's identity would appear to be characteristic of closed and coercive total institutions. It is a permanent feature of the institutions, an aspect of their obsession with security and social control.[40]

Goffman's and Davies' insights have clear implications for health care professionals working in the prison context and for this thesis. The institutional structure and dominant features which characterise total institutions will unavoidably impact upon the health of inmates and the delivery of health care. The processes of self-mortification and transmogrification - features of closed, coercive institutions - would create or exacerbate physical, but particularly mental, health related problems for (some) inmates. These processes also cause other problems of ethical significance. Goffman argues that the destruction of self, and subsequent transformation, impacts on an inmate's capacity to be self-determining, autonomous and free. Therefore, the ability of inmates to make autonomous health related choices will be deleteriously affected by having one's identity stripped away, humiliated and re-made.

It must be noted that not all prisoners, even those incarcerated for extended periods, have their identity 'stripped away'. In short, some prisoners are very resilient. This is not to deny Goffman's and Davies' argument, but to acknowledge that prisoners' social status, post release expectations, and education may influence the institution's ability to strip away identity.[41] In some cases, therefore, the ability of inmates to make autonomous health choices will not be adversely effected by incarceration.

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[40] *Ibid,* p92-93.

[41] See for example Lawson, DP. Segrin, C. Ward, TD. The relationship between prisonization and social skills among prison inmates, *The Prison Journal,* 76:3, 1996.

Enforced batch living and lack of privacy are features of total institutions described by both Goffman and Davies. The lack of privacy experienced by inmates is related to batch living and also attributable to the high level of surveillance inmates are subjected to. The absence of privacy in the prison context would clearly impact on health care professionals' ethical and professional obligations, especially confidentiality.

Isolation from family, friends and usual support networks would also influence the health of, and health care delivery to, inmates. This renders some, if not all, inmates vulnerable to exploitation by other inmates and those who work in total institutions.

It can also be posited that those who lack power and agency, in places where violence is prohibited or constrained, can only resort to manipulation in an attempt to gain some control over their environment. Since inmates are incarcerated in highly coercive environments, they may well try to manipulate health care professionals to make their life better or at least different.

Davies' comparative analysis of total institutions allows for a more fine-grained and systematic discussion of differences between the institutions. While maintaining many commonalities – prisons are prisons after all – the priorities of minimum and maximum security prisons vary. Establishing compliance was coercive in both contexts, and yet there is less coercion and less strict safety rules in minimum security prisons. The need for less security and less coercion may well impact on the work of doctors and nurses working in both maximum and minimum security correctional centres, though in different ways.

In the next section I will discuss the relevant work of Foucault. His discussion of social discourse, particularly on surveillance, discipline and transformation augments the work on total institutions by Goffman.

3.2.4 The Birth of the Clinic

Foucauldian scholars divide Foucault's work into two broad periods or dimensions. Gutting[42] argues the work done during the archaeology of discourse dimension is that of a philosophical historian who "developed a series of complementary historical methods". The second dimension, the genealogies of power relations, is that of a historicist philosopher "offering, parallel to his methodological innovations, successfully deeper and mutually supporting theories of knowledge, power, and the self."

No work on prisons could be complete without some discussion of Foucault and his analysis of power and knowledge. I will briefly discuss two of Foucault's texts from both major axes: *The Birth of the Clinic*[43] (*BC*) and *Discipline and Punish*[44] (*DP*). Both are about total institutions and both are about surveillance: the medical gaze in the clinic and the disciplinary gaze in prisons. While Foucault constructs medicine as a total institution, this claim is contestable. I would argue that medicine does have some features of a total institution; surveillance for example, however medicine is not a total institution in the same way as are prisons.

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[42] Gutting, G. Introduction Michel Foucault: A User's Manual in Gutting, G (ed) *The Cambridge Companion to Foucault* 2nd edn, Cambridge University Press, Cambridge, 2005, p.2.
[43] Foucault, M. *The Birth of the Clinic,* trans Sheridan, A.M. Tavistock Publications, London, 1973.
[44] Foucault, M. *Discipline and Punish: the birth of the prison,* trans Sheridan, A.M. Penguin, London, 1977.

The *BC* is a history of clinical medicine, its concepts and its practices. Gutting argues Foucault's approach to the 'archaeologies' – the history of concepts – draws on the approach taken by his friend Georges Canguilhem.[45] Foucault extends Canguilhem's approach so that

> [A]rchaeology is an important alternative to standard history of ideas, with its emphasis on the theorizing of individual thinkers and concern with their influence on one another. Foucault suggests... that the play of individuals' thought, in a given period and disciplinary context, takes place in a space with a structure defined by a system of rules more fundamental than the assertions of the individuals thinking in space. Delineating the structures of this space (the goal of the archaeology of thought) often gives a more fundamental understanding of the history of thought than do standard histories centred on the individual subject.[46]

In *BC* Foucault demonstrates how modern medicine replaced galenic medicine, thus medicine moved from the realm of fantasy and imagination to certain and objective knowledge. Foucault argues the reconceptualising of the role of the hospitals and the universities allowed for medical reform; and central to these reforms was the clinic. Medical students, instead of studying theology and philosophy in universities, were to be educated at the bedside. Medical curricula included study of *inter alia* anatomy, physiology, chemistry, botany, pharmacy, surgery, and pathology. Subjects were taught in medical schools and at the bedside on grand rounds.[47] These reforms led to "the medical gaze [being]... organized in a new way. First, it was no longer the gaze of any observer, but of a doctor endowed with the power of decision and intervention."[48]

Foucault's primary point is that the birth of the clinic allowed the locus of power and knowledge to shift from the patient to the doctor. Moreover, medical power and

[45] *Ibid.* p.7.
[46] *ibid.* pp.9-10.
[47] *ibid.* p.71
[48] *ibid.* p.89

control came to be sanctioned and supported by the State. Medical power, in principle, ought to be evident in the prison context. The various international declarations and codes make the medical role in prisons clear and unequivocal. But given the previous discussion of Goffman's work on total institutions, an obvious question must be raised. Can the hegemony of medical power be sustained in total institutions, particularly those as closed and coercive as prisons? Or will the medical gaze be tempered in the prison context? Goffman suggests the latter is true. He claims professionals who provide humane care including health care in total institutions are often dissatisfied. They are dissatisfied because they pursue their calling, and their professional aims and goals are subordinated to the goals and aims of the dominant (total) institution.

3.2.5 Discipline and Punish

DP traces the revolution in punishment from its gritty opening describing the execution of Damiens for attempting regicide to new forms of punishment exemplified in the modern penal institution. The show of brute and obvious State power evolved, Foucault argued, into more effective and more subtle forms of control through surveillance and transformation. This was aimed, Sullivan argues, at the soul.

> Where the old power was inflicted on the body of the condemned, the new micropowers aimed at the soul of the prisoner and did this in the privacy of the prison, indeed, within the privacy of the individualized cell and ultimately within the absolute privacy of the prisoner's soul. By means of quiet punishments, mild but repeated, privately enacted, increasingly solitary, and systematically applied over prolonged periods, the state gradually gained access to the soul of the prisoner, and eventually, it gained control.[49]

[49] Sullivan, RR. The birth of the prison: discipline or punish? *Journal of Criminal Justice,* 24:5, 1996, p.450.

Foucault argued enlightenment ideals informed the moral transformation of the criminal. These included notions of community redress and the desire to reform criminals so they could take their place back in society. Foucault argued these reforms are self-interested, humanitarian ideals.[50] Appropriate redress and transformation or reform necessitated the establishment of appropriate punishments, punishments which better fitted the crime. This in turn required detailed classification systems.[51] Enlightenment ideals of balance such as redress and reform, appropriate punishments and an obsession with taxonomies transformed the penal system.

DP is an attempt to examine punishment "as a political tactic, as a technique for the exercise of power."[52] More emphasis is on discipline, however, than punishment. Key to discipline is surveillance and self-control. Bodies become transformed into docile and compliant bodies.

> Discipline consists of a concern with control which is internalised by each individual: it consists of a concern with time-keeping, self-control over one's posture and bodily functions, concentration, sublimation of immediate desires and emotions – all of these elements are the effects of disciplinary pressure and at the same time they are all actions which produce the individual as subjected to a set of procedures which come from the outside of themselves but whose aim is the disciplining of the self by the self.[53]

Prisons are paradigmatic of Foucault's carceral system; a system which extends from the margins of society to its centre. Techniques of discipline and punishment broaden to include all members of society.

> [The carceral system] includes not only the prison-institution, the realisation in stone and steel of a certain architectural plan, with its staff and its regulations, but also the whole range of techniques for the control and transformation of individuals, the various techniques for the extraction of a knowledge of individuals and the discourses thereby elaborated, and finally, the range of

[50] Merquior, JG. *Foucault,* Fontana, London, 1985, pp.89-91.
[51] *Ibid,* p.91.
[52] Sheridan, A. *Michel Foucault: the will to truth,* Tavistock Publications, London, 1980, p.138.
[53] Mills, S. *Michel Foucault,* Routledge, London, 2003, p.42.

> functions fulfilled by those techniques of power and knowledge; from the reproduction of criminality itself to the fabrication of "normal" individuals.[54]

Foucault's work is not without criticism. Merquior, for example, argues *DP* is factually wrong, and involves "lop-sided evaluations of historical data."[55] This refers to Foucault's argument that disciplinary roots lie in the Enlightenment. Merquior argues this is simply not the case. He also argues that Foucault's explanations are in and of themselves, problematic. His arguments are either circular or absent. Merquior explains that Foucault's explanation for why imprisonment in penitentiaries was quickly and almost universally adopted was because of class domination. He notes, however, that prisons also appeared in countries with little class conflict – America for example.[56]

Sullivan is also critical of *DP*. He argues the modern prison is more moral than Foucault allows. He maintains Enlightenment reformers interested in criminal justice – Bentham and Beccaria specifically – concentrated on punishment not discipline. Indeed Sullivan argues Bentham was concerned that discipline ought not to be the focus of prisons; rather prisons ought to be about punishment. Bentham cited in Sullivan, argued punishment was the key to deterrence. Thus sanctions of law must be "on the right intensity, duration, certainty, and propinquity of pain and pleasure."[57] Beccaria too was interested in punishment for reasons of deterrence, but while he argued for the importance of punishment, he was opposed to torture and the death penalty. He notes:

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[54] Patton, P. Of Power and Prisons: Working paper on *Discipline and Punish,* Patton, P. (eds) *Michel Foucault: power, truth, strategy,* Feral Publications, Sydney, 1979, p.114.
[55] Merquior, *op cit,* p.104.
[56] *Ibid,* p.106.
[57] Sullivan, *op cit,* p.454.

> [I]t is not the intensity of punishment that has the greatest effect on the human spirit, but its duration, for our sensibility is more easily and more permanently affected by slight but repeated impressions than by a powerful but momentary action.[58]

Perhaps more relevant to research in prisons are criticisms by Alford. After spending fourteen months as a researcher in a maximum security American prison, Alford was struck by the absence of Foucauldian practices. His research found that power was not exercised through disciplinary practices, notably surveillance and classification, but rather power was exercised in prison by not looking and not classifying.

> Surveillance, categorisation and classification, the time-table, non-idleness, and regimentation of the body: all are the mark of modern discipline according to Foucault. All, he says, originate in the prison, the asylum, and the clinic, subsequently migrating to the rest of society. What happens when we look closely at the prison and find none of them there, at least not in the sense that Foucault intends? Not only are these disciplinary practices absent, but what is in effect the opposite principle reigns: if you control the entrances and exits, you do not have to look. Prison authorities don't look because they do not have to. If you have to look, you have already ceded a measure of power, the power not to look and not to care.[59]

Alford's point about the power of not caring is an interesting one. He argues that various practices within prisons, for example inmates attempting to create some measure of privacy by covering their walls with opaque material which is strictly against the rules, is ignored by the custodial officers. The reasons why such practices were tolerated he explains was "not because guards have learned new respect for the prisoners' privacy, but because the guards don't care."[60] Not looking and not caring extends to what prisoners do with their time. Prisons are places in which men and

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[58] Berraria, C. *On crimes and punishments,* Paolucci, H. (trans), Prentice Hall, Englewood Cliffs, 1963, pp.46-47, cited in *Ibid.*

[59] Alford, CF. What would it matter if everything Foucault said about prison were wrong? *Discipline and Punish* after twenty years, *Theory and Society,* 29, 2000, pp.126-7.

[60] *Ibid,* p.131.

women are idle, and their time unstructured,[61] a very different experience to Foucault's disciplinary space.

Hacking argues Foucault's and Goffman's works on total institutions are complementary. Goffman's total institutions are about stripping away an inmate's identity and transforming or re-making it, and Foucault's 'disciplinary techniques' are an account of the means by which people are re-made by imposing practices of discipline.

> The human body was entering a machinery of power that explores it, breaks it down and rearranges it... it defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practised bodies, 'docile' bodies.[62]

These disciplinary techniques are not merely superimposed on the social order. As Rouse notes "these practices produced new *kinds* of human subjects (emphasis in original).[63] It must be noted that Foucault does take inmate's resistance into account. He argues power relationships are a dynamic struggle or war: power is not imposed in a unidirectional way from the top down.[64]

3.3 The Prison System in NSW

In this section I will discuss the historical context of prisons and prisoners in NSW, including their medical care. This examination will also involve a brief discussion of the importance of prison architecture.

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[61] *Ibid.*
[62] Foucault, M. *DP op cit,* p.138.
[63] Rouse, J. Power/Knowledge, Gutting, G. *op cit,* p.100.
[64] See Foucault, M. *The History of Sexuality, Vol. 1: An Introduction,* trans Hurley, R. Pantheon, New York, 1985 for discussion of power networks and especially Foucault, M. in Gordon, C. (ed) *Power/Knowledge: Selected Interviews and Other Writings 1977-1984,* Pantheon, New York, 1980.

3.3.1 The Purpose of Prisons

According to the Shorter Oxford English Dictionary Prison "*orig.* The condition of being kept in captivity or confinement; imprisonment; hence, a place in which such confinement is ensured."[65] Encarta defines prisons as institutions "designed to securely house people who have been convicted of crimes. These individuals, known as prisoners or inmates, are kept in continuous custody on long-term basis."[66] Encarta also states that imprisonment:

> serves several universal functions, including the protection of society, the prevention of crime, retribution... against criminals, and the rehabilitation of prisoners. Additional goals of imprisonment may include the assurance of justice based on a philosophy of just deserts...[67]

3.3.2 The Convicts

Australia was settled by Europeans as a penal colony. Conditions in Britain including prison and hulk overpopulation, the American War of Independence the outcome of which ended transportation of prisoners to the Americas, changing views of capital punishment and penal reform made transplantation a (continuing) suitable solution to the problem of criminality and punishment. From 1788 until 1869 more than 150,000 convicts were transported to Australia, 80,000 of whom were sent to New South Wales (NSW). In total about 24,000 of these convicts were women,[68] the majority of whom were sent to NSW. Transportation of convicts to NSW ended in 1840.

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[65] Little, W. Fowler, HW. Coulson, J. (prep) Onions, CT. (ed) *The Shorter Oxford English Dictionary on Historical Principles* 3rd edn , Vol 2, Clarendon Press, Oxford, 1964, p.1586.
[66] *Encarta,* http://encarta.msn.com.text_761573083_1Prison.html accessed 29.11.2004.
[67] *Ibid.*
[68] Hughes, R. *The Fatal Shore: a history of the transportation of convicts to Australia, 1787-186,* Collins Harvill, London, 1987, p.244.

The convicts transported to Australia were mainly young, male, convicted for property crimes, recidivists, and urban dwelling. Overwhelmingly, the convicts came from the lower classes.[69] Robinson describes the situation of the convict women transported to Australia:

> [T]hey were women who [were] familiar with the exploitation of child labour, with poor working conditions, with overcrowded and unsanitary housing in cottage, room or lodging; women who had known and lived through dangers of infant, child and juvenile disease and who, in many cases, had survived childbirth and the complications of lying-in.[70]

It was several decades before a comprehensive regime of imprisonment and punishment was implemented in the colony. Male convicts had a great degree of freedom while women were significantly more restricted. Moreover, women proved more problematic for the government. Hirst argues that the sole function of women convicts, from the standpoint of the British government, was as prostitutes. While the government advocated marriage for convict women "[M]arried or single, the women presented a special difficulty to the governors: there was little demand for them as workers."[71]

Governor King's solution to the problem of women was to build a cloth factory in Parramatta in 1804. As the numbers of women convicts increased, pressure was placed on the original building, and some women had to sleep outside the Factory. To house themselves most women either lived with men or prostituted themselves to pay for rent. The Reverend Samuel Marsden objected to this practice:

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[69] Hirst, J. The Australian Experience: The Convict Colony, in Morris, N. & Rothman, DJ. (eds) *The Oxford History of the Prison: The practice of punishment in western society,* Oxford University Press, Oxford, 1995, p.265.
[70] Robinson, P. *The Women of Botany Bay: A reinterpretation of the role of women in the origins of Australian society,* Macquarie Library P/L, 1988, p.14.
[71] Hirst *op cit,* p.272.

> [T]here is not a bushel of wheat or maize in the farmer's barn, nor a sheep in his fold, nor hog in his stye-nor even a potato, turnip or cabbage in his garden- but what he is likely to be robbed of every night... to supply the wants of these abandoned women, to whom the men can gain access at all times of the night.[72]

Women convicts/prisoners were considered more problematic in terms of what to do with them and because of their alleged immoral and depraved ways. The colony was not organised to accommodate women. The only solution was to confine them. The problem of what to do with women prisoners is a reoccurring one.

3.3.3 Prison Architecture

Prior to the construction of prisons in NSW, a variety of methods for containing and punishing miscreants were employed. [73] When constructed, prisons were utilitarian in purpose and design. The cell design followed contemporary European norms. Architectural design closely followed trends in England and, moreover, provided normative values to the burgeoning colony. Governor Macquarie, for example, built gaols not only to confine, but to inspire.

The Female Factory, now sometimes known as the Female Penitentiary, provided confinement for women who had committed a crime in the colony, and those without work. The Female Penitentiary was also the site of the first classification system of convicts in Australia. Third class prisoners were those who committed a crime in the colony. Good behaviour allowed them to progress through the classes to first class. First class included women awaiting work, convicts newly transported and pregnant

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[72] Marsden, S. An Answer to the Calumnies of the Late Governor Macquarie's Pamphlet 1862 cited in Hughes *op cit*, p. 255.

[73] Kerr, JS. *Out of sight, out of mind: Australia's places of confinement 1788-1988*, National Trust of Australia, Canberra, 1988, p.21-2.

women.[74] The Factory also contained six cells for isolating prisoners. The women convicts of NSW "were the first to experience the punishment of cellular isolation..."[75]

Under Governor Gipps the Female Factory was further extended to allow for more suitable confinement for the 'penal class'. Kerr explains that Gipps wanted to "devise a punishment which was increased in degree from the separate confinement that was then the only punishment, short of execution, to which women could be sentenced".[76] Unfortunately for Gipps, the English prison inspectors rejected his plans, stating the obvious problems of solitary confinement in non-ventilated and dark cells and that "dark cells produced no moral benefit."[77]

From the above we can see prison ideology was changing. The move was away from the inspirational and open space in which convicts had a fair degree of freedom, to the Silent System and the Separate System.[78] This policy supported the idea that prisoners should be isolated from one another physically and forbidden to communicate with one another. It was thought that prisoner-to-prisoner contact would spread criminal tendencies.

About the time the first fleet arrived in NSW, Jeremy Bentham was arguing for his social and moral panacea, the Panopticon (1791). Ignatieff[79] argues Bentham

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[74] Hirst, *op cit.*
[75] *Ibid.*
[76] Kerr, *op cit,* p.45
[77] *Ibid.*
[78] New South Wales Department of Corrective Services *The First 200 Years* 1998 http://www.dcs.nsw.gov/about/history.asp accessed 16.7.2004.
[79] Ignatieff, M. *Just a measure of pain: the penitentiary in the industrial revolution 1750-1850* Macmillan, London, 1978

understood his Panopticon – a circular building which allows for constant observation of prisoners – to be the architectural solution for social ills.

> Morals reformed – health preserved – industry invigorated – instruction diffused – public burdens lightened – economy seated as it were upon a rock – the Gordian knot of the Poor Laws not cut but untied – all by a simple Idea in Architecture![80]

Importantly, the Panopticon made the inspection and control of space less important.

> The panoptic mechanism arranges spatial unities that make it possible to see constantly and to recognize immediately...Each individual, in his place, is securely confined to a cell from which he is seen by a supervisor; but the side walls prevent him from coming into contact with his companions. He is seen, but he does not see; he is the object of information, never the subject of communication.[81]

The importance of architecture in controlling prisoners continues to this day. Interestingly, architecture was specifically employed to solve the practical and moral problem of women.

3.3.4 Medical and Nursing Care

Prior to the transportation of convicts the British Government saw the need for provision of medical care on the voyage and in the new settlement. Five surgeons, under the direction of the Surgeon-General and head of the Colonial Medical Service (CMS), John White, sailed with the first fleet. Of the 759 convicts on the transports, 16 died before sailing and there were 24 deaths on the voyage.[82] White believed in good diet, plenty of water, exercise, fresh air and clean living quarters.[83]

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[80] Bentham, J. *Panopticon* p.1 cited in *ibid.*
[81] Foucault, M. *op cit,* p.200.
[82] Proust, AJ. *A companion of the history of medicine in Australia 1788-1939,* Proust, Canberra, 2003, p.12.
[83] *Ibid,* pp.12-3.

On the journey to Australia, the women convicts had their own difficulties. White noted that the women were prone to problems associated with the heat and humidity. The solution - the provision of fresh air to the women's quarters – was not an option because, White recorded, "their depravity was such, the hatches could not be opened at night without leading to promiscuous intercourse with seamen and marines."[84]

While the British government had the foresight to employ competent medical staff, the need for nurses or midwives was apparently not considered. This oversight is telling, given there were 190 convict women and 25 free women on the voyage. Moreover, the surgeons who were employed had mainly military medical experience; this, understandably, did not include obstetric experience. Hospital nursing and midwifery was practised by the patients themselves and later by convict women employed by the government.[85]

The regulation of medicine began in 1808 with the appointment of a board to scrutinise medical qualifications and/or skills of applications for assistant surgeon positions. This was followed by the Medical Act of 1838 and establishment of the NSW Medical Board.[86] The first trained nurses arrived in the colony in 1838. The two trained nurses, the Sisters of Charity, were sent to work in the Parramatta Female Factory by the Bishop and helped to establish St Vincent's Hospital in 1857.[87] Formal midwifery training began in 1862 at The Woman's Hospital followed by a

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[84] White, J. *Journal of a Voyage to* new [sic] *South Wales with sixty-five plates of non-descript animals, birds, lizards, serpents, curious cones of trees and other natural productions,* cited in *ibid,* p.7.
[85] Perrott, M. *A tolerable good success: economic opportunities for women in New South Wales 1788-1830,* Hale and Iremonger, Sydney, 1983, p.35.
[86] Proust *op cit,* p. 228.
[87] *Ibid.*

school of nursing at the General Hospital (now Sydney Hospital) in 1868 under the control of Lucy Osburn, a Nightingale trained nurse.

Several issues and themes arise about the treatment of women convicts in NSW. The first was that they created practical problems for the government. Finding appropriate and sufficient work in the new colony for these women was difficult. Unlike the male convicts who were responsible for finding their own accommodation, these women had to be housed by the administration. Moreover, their different health care needs were problematic. Secondly, they posed a significant moral problem. This is attributed to the nature of the women themselves. The third problem was how to reform these women. Various methods, including the use of architecture, were adopted. The overriding impression is that the needs of women convicts were not considered by the British government. Therefore their different needs became problems because women convicts did not fit easily into the arrangements made for male convicts.

3.4 Department of Corrective Services

NSW Department of Prisons became the Department of Corrective Services in 1969 because "the notion of corrective services was thought to represent a more holistic endeavour. It more accurately represented the effort to correct behaviour, to re-educate and treat the criminality or offending behaviour."[88] The shift in emphasis from punishment to correction also saw the term 'prisoner' being replaced with a more neutral term of 'inmate'.

[88] O'Toole, S. *The History of Australian Corrections,* UNSW Press, Sydney, 2006, pp.159-60.

To date, DCS manages thirty-one correctional centres across NSW, of which ten are minimum security centres; thirteen are classified as medium security centres and eight maximum security correctional centres. The classifications refer to the level of security risk of the inmates. Maximum security centres, for example, "hold inmates whose escape would be highly dangerous to members of the public or the security of the State," and minimum security centres "hold inmates who can be trusted in open conditions where there are fewer physical barriers to escape."[89] At the time of carrying out the interviews for this research there were two dedicated women's prisons in NSW: one minimum security correctional centre and one combined maximum, medium and minimum security correctional centre. A medium security correctional centre has since been opened. This research was carried out at the minimum security correctional centre and the combined maximum, medium and minimum security correctional centre. For the purpose of this thesis the combined maximum, medium and minimum security correctional centre will be referred to as the maximum security facility.

The most recent *Annual Report* states the DCS Mission is to "manage offenders in a safe, secure and humane manner and reduce the risks of re-offending. The vision of the institution is to "contribute to a safer community through quality correctional services." Institutional principles include the safety and well being of its staff, the safety and welfare of offenders, equity, respect for individuals and accountability.[90]

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[89] New South Wales Department of Corrective Services, *Offender Management,* available at http://www.dcs.nsw.gov.au//offender_management/offender_management_in_custody/index.asp#2 accessed 25.7.08.

[90] New South Wales Department of Corrective Services, *Annual Report 2007/07,* Available at http://www.dcs.nsw.gov.au/information/publications/Annual_Reports/Annual_Report_2006-2007/annrep07web.pdf, accessed 25.7.08.

While the vision of the current *Annual Report* has changed from the period when the research was undertaken, the mission remains unchanged.

3.4.1 Health Care and the Division of Labour

DCS employs staff in both administrative/management and operational areas. Some staff have little contact with inmates while others work directly with them. The latter includes staff whose main role is security, for example correctional officers and probation and parole officers, but it also includes those involved in education, including trade teachers and staff who work in offender services. Interestingly, DCS also employs professionals whose roles and tasks are usually considered to be health care roles and tasks. These include psychologists, welfare officers, risk managers, mental health nurses, and drug and alcohol counsellors.

3.5 Justice Health

Control of the Prison Medical Service was transferred to the NSW Department of Health in 1968.

> In the early 1990s, during a period of reform to healthcare delivery in correctional centres, the Prison Medical Service became the Corrections Health Service and in 1994, the service was designated a statutory health corporation. In 2004 the service became known as Justice Health, in recognition of the work we do in the community and courts as well as in correctional facilities.[91]

JH is responsible for the health care of all adult and juvenile inmates and detainees, as well as discharge planning. Clinical services include the provision of nursing and medical care, primary health care, women's health, mental health, drug and alcohol services and Aboriginal health care. Primary health care is provided by nurses and

[91] Justice Health. Available at http://www.justicehealth.nsw.gov.au/2nd_level/about_justice_health.html accessed 25.7.08.

secondary care by doctors. Specialist care is provided either within the correctional facilities or at tertiary public hospitals.

In the most current *Annual Report* JH's mission is:

> [A]chieving measurable and sustained health care outcomes leading to international best practice for those within the NSW Criminal Justice System.[92]

3.6 The Prison Population

Context not only includes correctional institutions, administration and staff, it also includes patients. In this section, I will briefly outline the health care profiles of women prisoners in NSW gaols.

3.6.1 Women Prisoners and Special Needs

Both DCS and JH recognise women inmates may have special and different requirements and needs from men. These needs include women's social and educational circumstances and how women cope with incarceration. According to DCS, women's criminogenic[93] needs "must be contextualised within the realities of their social, vocational and economic circumstances and women's specific patterns of learning and interacting with peers and authorities."[94]

Research from the United Kingdom has identified that incarcerated women have a higher prevalence of the following than the general community:

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[92] Justice Health, *Annual Report 2005-2006,* Matraville, 2006. Available at http://www.justicehealth.nsw.gov.au/pubs/jh_ar_05-06.pdf, accessed 25.7.08.
[93] Criminogenic refers to dynamic risk factors including alcohol and drug addiction.
[94] NSW Department of Corrective Services, *Women's Action Plan 2 2000-2003,* 2000, p.4.

- sexual, physical and emotional abuse;
- substance abuse, particularly poly-drug and heroin use;
- self-harm and attempted suicide;
- poor employment and poor educational histories;
- severe emotional or mental problems.[95]

Australian research has found women offenders "face distinct issues related to their social roles as women, mothers and carers." These include:

- early experiences of sexual and physical abuse;
- mental health issues;
- social stigma related to drug abuse and offending;
- caring for children and other relatives;
- poverty associated with being single parents; and
- disease and abuse associated with sex work.[96]

The issues of pregnancy and motherhood are problematic in prisons. With the rapid increase of young women imprisoned or on remand pregnancy has become a significant issue. Pregnant women on remand or those who have been sentenced and incarcerated in either a maximum or medium security correctional centre are unable to keep their infants and/or young children with them. This creates significant difficulties for these women including issues of who should care for their babies or children in their absence, and how to maintain mother/child relationships while in prison. Appropriately classified women in minimum security facilities and under stringent security conditions are able to keep their babies and young children under five with them. Many imprisoned mothers feel guilty about abandoning their children, and since a large minority of women in prison have themselves been in care during childhood they have concerns about their own mothering skills. Maintaining relationships with significant others is also problematic while they are in gaol.

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[95] Byrne, M. Howells, K. *Key issues in the provision of correctional services for women*, Women in Corrections: staff and clients Conference, Australian Institute of Criminology and the Department of Correctional Services SA, Adelaide, 31 October - 1 November 2000, p.2.
[96] Johnson, H. *Drugs and Crime: a study of incarcerated female offenders,* Australian Institute of Criminology, Australian Government, Canberra, 2004, p.11.

3.6.2 2001 New South Wales Inmate Health Survey

Two comprehensive health surveys have been undertaken by CHS. The first was completed in 1996 and the second in 2001. Both surveys aimed to provide epidemiological data on the prisoner population in NSW to improve the delivery of health care to prisoners.

The sample includes thirty-four percent of women inmates in full-time custody. The major health care problems of women prisoners are listed below.

- 31% tested positive for hepatitis core-antibody;
- 64% were hepatitis C antibody positive;
- scores on all eight dimensions of the SF-36 were lower than for the general community (the SF-36 is a multi-purpose, short-form health survey);
- 95% had at least one chronic condition;
- 18% scored below the pass rate on the intellectual disability screener;
- Over 33% drank alcohol in the 'hazardous' or 'harmful' range according to the Alcohol Use Disorders Identification Tool;
- 83% were current smokers;
- 84% had used illicit drugs at some time of their life: 74% had used illicit drugs regularly in the twelve months before prison;
- Over 75% thought it was 'quite easy' or 'very easy' to get drugs in prison;
- 60% had been sexually abused before the age of 16; 30% had been sexually abused before the age of 10;
- 33% had been through the childhood care system.[97]

The most common health complaint for these women was tiredness/energy loss, followed by headaches and sleeplessness.[98] Analgesics were the most frequently dispensed medication with 48% requiring these in the two weeks period before the survey. Of the respondents, 24% of women were prescribed psychiatric medications and 39% were taking methadone.[99]

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[97] Butler, T. Milner, L. *2001 Inmate Health Survey,* Corrections Health Services, Sydney, 2003, pp.8-9.
[98] *Ibid,* p.46.
[99] *Ibid,* p.47.

Injuries were fairly common and, according to the survey, reflects the violent environment. "The most common cause of injury for both sexes was being struck by an object or person... (32%).[100] Head injuries leading to unconsciousness and with persistent side effects were particularly problematic and affected 39% of women. As with other injuries, most of these resulted by being struck from objects or persons (69%).[101] Infectious diseases were common in the prisoner population as were Herpes Simples Types 1 (89%) and 2 (51%) and sexually transmitted diseases (41%).[102]

The survey reports that 58% of women regularly use the prison clinics for routine medications: mainly for methadone and psychiatric medications. Prisoners only have access to over the counter medications at the prison clinics, consequently there is a high demand for such services.[103]

Overall, both male and female inmates rate their satisfaction with prison clinics and the health care provided as 'excellent' or 'fairly good'. The survey notes that there is greater satisfaction with the standard of health at smaller and rural prisons. The larger, older prisons tend to rate less well. Inmates at the minimum security correctional centre this research was carried out in rated the overall standard of health care as 'good' (53.2%), 'average' (37.7%) and 'poor' (9.1%). Inmates at the maximum security correctional centre rated the overall standard of health care as 'good' (7.6%), 'average' (29%) and 'poor' (63.4%).[104] The main complaints at both prisons relate to access to doctors and dentists. Specific complaints with the

[100] *Ibid,* p.63.
[101] *Ibid,* pp.66-67.
[102] *Ibid,* p.76.
[103] *Ibid,* pp.49-50.
[104] *Ibid,* p.51.

maximum security prison also relate to health care staff attitudes to patients, such as not respecting them, and fobbing them off with over the counter medications (Panadol) rather than having their health complaints taken seriously. Some prisoners were also critical of the attitudes of the officers who staff the clinic.[105]

3.7 Inquiries and Royal Commissions into NSW Prisons

O'Loughlin, following others, has suggested that inquiries serve the dual purpose of providing expert advice and stakeholder input to governments and to provide a politically expedient way of attending to difficult social issues.[106] Fenna argues:

> [A]mong other things, inquiries can help delay having to deal with intractable issues, deflect criticism of unpopular decisions, re-define the problem in a way more congenial to the ideological preconceptions of the government, or allow the Government (sic) to change its mind or abandon a policy commitment.[107]

In this section, I will briefly discuss three recent Commissions of Inquiry and Reports which have, to various degrees, mandated reform of the prison system in NSW, with specific emphasis on remarks about the provision of health services to prisoners. I will begin with the 1978 Nagle Royal Commission.[108] This report is perhaps the most important in terms of its impact and the reach of its reform agenda. The second report considered in this section is the Women's Task Force Report 1985.[109] This report is a continuation of the Nagle Report as it addressed the situation of women prisoners, neglected by Nagle. The third report is the NSW Ombudsman's Report.[110] This report dealt with several complaints – the sex-for-favour network allegations and a

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[105] *Ibid,* p.212-6.
[106] O'Loughlin, K. *Policy and politics in work-injury management, NSW, 1926-1987,* PhD Dissertation, The University of Sydney, 2001.
[107] Fenna, A. *Introduction to Australian Public Policy,* Longman, South Melbourne, 1998, p. 108.
[108] Nagle, JF. *Report of the Royal Commission into New South Wales Prisons*, March 1978.
[109] Report of the NSW Women in Prison Task Force, 1985.
[110] NSW Ombudsman, *Mulawa Report,* Government Publishing Service, Sydney, 1997.

story in a Sydney newspaper reporting an alarming increase in the number of self harm incidents and complaints about substandard medical care from inmates. I will be concentrating on issues pertinent to the main concern of this thesis – the experiences of nurses and doctors working within female correctional centres.

3.7.1 The Nagle Royal Commission

In March 1978 The Honourable Mr Justice Nagle handed down his report on NSW prisons. The brief of the Nagle Royal Commission was to:

> [I]nquire into and report upon the general working of the Department of Corrective Services of New South Wales, its policies, facilities and practices in the light of contemporary penal practice and knowledge of crime and its causes and, without restricting the generality of the foregoing to inquire and report upon:
>
> (a) The custody, care and control of prisoners and the relationship between staff and prisoners;
>
> (b) The selection and training of prison officers and of other staff engaged in training, correctional and rehabilitative programmes for prisoners
>
> and to recommend any legislative and other changes necessary or desirable in consequence of [the] findings.[111]

This Report, in three volumes, provides the most comprehensive and far reaching inquiry into the correctional system in NSW and its findings have altered correctional systems throughout Australia. Indeed, O'Toole argues "[T]he 1978 Nagle Royal Commission into NSW prisons is arguably the most significant examination of an Australian prison system in the modern era."[112] Moreover, the Report led to a huge improvement in enhancing prisoners' rights.[113]

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[111] *Ibid,* p.22.

[112] O'Toole, S. From enemy of the state to incarcerated citizen – the history of management in Australian Corrections *Australasian Journal of Correctional Staff Development,* 1:2, 2005.

[113] Dawes, J. Institutional Perspectives and Constraints, History in Brown, D. & Wilkie, M. *Prisoners and Citizens: Human Rights in Australian Prisons,* The Federation Press, Sydney, 2002, p.117.

3.7.1.1 Medical Services

The provision of health care to inmates was the responsibility of the Health Commission under the aegis of the Department. Nagle argued these services for were unsatisfactory as the "health care of prisoners was a secondary consideration."[114] Secondary, that is, to custodial concerns.

The provision of medical services to prisoners is mandated under the United Nations Minimum Rules for the treatment of prisoners, outlined in the previous chapter. Nagle reported Australian legislation also mandated appropriate medical care and services. The Prison Act (1952) expressly stated that prisoners must be supplied with medical care at the public expense for the purpose of maintaining the overall health of prisoners and to alleviate any chronic condition which may hinder their rehabilitation. The Act also states prisoners must comply with medical treatment ordered by the medical officer.[115]

In general, Nagle found that there was a lack of adequate medical services for prisoners, contrary to the requirements of the Act. He found there was a shortage of appropriately qualified medical staff in the prison system and that requests by the Prison Medical Service for more staff were often ignored. Furthermore, he was highly critical that one low cost and efficacious procedure, general screening to identify drug users, which could help in the rehabilitation of prisoners, was not implemented.

[114] Nagle *op cit*, p.502.
[115] *Ibid*, pp.503-4.

Nagle also noted unacceptable waiting times for access to outside institutions, usually public hospitals, for specialist medical care. He cited the case of a prisoner who, unable to get appropriate treatment for an injured shoulder, escaped and underwent surgery at Manly Hospital before being re-captured.[116]

While the Prison Medial Service was responsible for the medical needs of prisoners, Nagle argued the DCS also had a duty to ensure prisoners under its care received suitable medical treatment.

3.7.1.2 Women Prisoners

Nagle suggested that many of the problems women prisoners faced were similar to those of men. He did find, however, that women had specific problems which related to their particular medical needs, their different coping strategies or lack thereof, and/or because women made up such a small percentage of the total prisoner population.

At the time of the inquiry the maximum security correctional centre was the only dedicated women's prison. The women prisoner population was fairly stable, although, in the last decade, there has been an exponential increase in the number of women prisoners.

Nagle was sceptical of the Department's claims that the women received comprehensive medical, psychiatric, dental and gynaecological care.

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[116] R. v. Tanzir Danach, C.C.A., 12th August, 1977, p.2 cited in *Ibid,* p. 514.

> It is more probable that a more accurate assessment can be made of the adequacy of the medical care provided to the inmates at [the prison] by the fact that in 1976 the custodial staff at [the prison] saw fit to initiate industrial action, complaining of the inadequacy of medical services available for the prisoners.[117]

The dispute at the maximum centre facility centred on the problem that twenty-four hour nursing care was not provided to the prisoners. No nurses were on duty between the hours of midnight and 8am. Consequently prisoners were medically unattended between those times. Even if the nurses were called to see a prisoner after hours, they could not readily or easily do so because the inmates were locked up in their dormitories at 5pm. It was possible for the nurses to see a patient for medical purposes after hours, but it required that a senior member of the custodial staff unlock the area and that the visit be supervised by them.

Nagle argued there was no direct supervision, or adequate supervision, of the medical staff. He also noted there was inadequate medical care of patients, specifically and including the lack of routine obstetric and gynaecological care, and psychiatric care. Nagle argued that the lack of psychiatric care had led to an "extensive overuse of tranquillizers"[118] by the doctors.

With respect to obstetric care, Nagle found none of the nurses working at [the prison] had a midwifery certificate. Nor were the nutritional needs of pregnant prisoners properly addressed. Adequate and responsive gynaecological care of the women inmates was also problematic. Nagle reported that the nurse in charge of the clinic was male and there had been complaints from patients about him doing vaginal examinations on them. Nagle reported that the complaints about the attitudes of the

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[117] *Ibid*, p.570.
[118] *Ibid*, p.572.

nursing staff go back to 1966. And, importantly he noted, there was also a history of bad relations between nursing and custodial staff.

Prisoners with psychiatric conditions did not fare any better. Nagle noted that the shortage of psychiatric care would have a detrimental effect on the prisoners' psychiatric condition and on their ability to be successfully rehabilitated and reintegrated into the community. He also queried the habit of over-sedating disturbed inmates as well as the over-use of sedatives generally. Instead of counselling, the inmates were medicated.

Many of the women inmates had a history of drug and alcohol abuse. Unfortunately, there were no detoxification treatments for drug using prisoners nor were there any follow up treatment programs for addicts.

Nagle also noted that there were long delays in getting medical attention because:

> [T]his depended on a decision by a member of the custodial staff, and long delays occurred before people with psychiatric histories, obviously ill, received treatment.[119]

Follow-up care was also difficult to arrange. One woman with septicaemia went untreated until custodial staff intervened and she was taken to hospital. In another case an inmate complaining of a breast lump was not referred for further investigation; and one woman had an ectopic pregnancy which went undiagnosed.

The routine medical examination of inmates at reception was poor. Nagle found that prisoners with psychiatric conditions, who should have been transferred to a

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[119] *Ibid.*

psychiatric centre, were admitted to the prison. When patients with severe psychiatric conditions were diagnosed and the medical staff requested their transfer to a proper psychiatric unit for observation and treatment, tardy documentation by the DCS led to unnecessary delays in transferring these patients.

The Prison Act (1952) required that medical staff be responsible for those aspects of prison life which might reasonably be seen to impact on the health care of prisoners. Nagle found the dormitory accommodation of prisoners problematic because of the lack of privacy. This exacerbated the "adverse psychiatric effects of imprisonment on women – tension, bitterness and aggressiveness."[120] Cellular accommodation was also problematic.

> The cells used as the "pound" or punishment cells at [the prison] are as bad, if not worse, than those in many New South Wales prisons... The cells, as well as being used for punishment, accommodate seriously disturbed psychiatric patients. During the day, all the bedding is removed from the cells; only a mat is left.[121]

3.7.1.3 Legacy of the Nagle Royal Commission

Brown argues that inquiries can be analysed *inter alia* by three key criteria: the ability of the inquiry to (1) establish the truth, (2) settle accounts, and (3) stimulate long-term reform. [122] Hancock and Leibling maintain truth-telling, or "the extent to which inquiries appear to establish accurately both the *reality of what happened* in a given set of circumstances and *knowledge as understanding about the organisation concerned*"[123] are central to the success of inquiries.

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[120] *Ibid,* p.575.
[121] *Ibid,* p.576.
[122] Brown, D. Commissions of inquiry and penal reform in O'Toole, S. Eyland, S. (eds) *Corrections Criminology,* Hawkins Press, Annandale, 2005, p. 44.
[123] Hancock, N. Leibling, A. Truth, independence and effectiveness in prison inquiries, in Gilligan, G. Pratt, J. (eds) *Crime, Truth and Justice,* Willan, 2004, p.100 cited in *ibid.*

The Nagle Inquiry, Brown maintains, was largely successful in establishing the truth about penal practices and culture in NSW. This was achieved against great opposition from the Commissioner, prison officials, the officers and their union.

Settling accounts refers to the ability of the inquiry to ascertain individual and institutional accountability. This step – disciplining and possibly removing those responsible – is necessary for reform to occur. Brown argues that the Inquiry failed to properly settle accounts and that the failure "to prosecute or otherwise discipline certain prison officials, officers, and others ... undermined the capacity of the new administration... to bring about the extent of change envisaged and authorised by Nagle."[124]

Vinson headed the new prison administration authorised to implement the changes recommended by Nagle. Clearly, stopping the systematic abuse of prisoners by prison staff was the most successful outcome of the Nagle Report. As too were the recommendations about the need to improve prison officer education, training and professionalism. Understanding that prisons are places of punishment and not a means of rehabilitation introduced a note of realism, and changed "the status of imprisonment from being a standard response to crime to one requiring justification in terms of the limited things gaol has to offer – essentially isolation and punishment."[125] Other improvements were less successful, particularly those involving the notion of prisoners' rights. Vinson states:

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[124] Brown, *op cit,* pp.47-8.
[125] Vinson, T. Implementing the key principles of the Nagle Commission' *Current Issues in Criminal Justice,* 16:1, 2004, p.96.

> I cannot remember staff enthusiasm for implementing any of the relevant Royal Commission recommendations. Things like extended visits, contact visiting and the reduction of overnight lock-ups to 10 hours. There was little staff enthusiasm for a regular gynaecological consulting service for women prisoners... as well as the decision to make it no longer mandatory for mothers to surrender their infant children on their first birthday. We were told that implementing the recommended unlimited and uncensored correspondence (after checking for the presence of contraband) as well as supervised telephone calls was unworkable. The introduction of these measures was almost invariably accompanied by prevarication, the direct involvement of the Commissioners, and frequently by staff taking industrial action.... The point is that the tradition of prisoners having absolutely no rights runs very deep in our penal tradition...[126]

Key features of Goffmanian total institutions are evident in the inquiry. Goffman describes total institutions as particularly impermeable and rigid, impervious to reorganisation. Brown's argument that Nagle's inquiry failed to 'settle accounts' necessary for institutional change and Vinson's experience of trying to introduce institutional reform attests to the institution's implacable resistance to change.

Goffman and Davies argue that relationships between staff and inmates are created and shaped by total institutions. The sharp divisions between the correctional staff and inmates and marked hostility between the two groups was commented upon by Nagle. The hostility felt by custodial staff towards inmates gave rise to systematic abuse and denial of prisoners' rights.

Surveillance and security, Foucault, Goffman and Davies argue, are key activities of prisons/total institutions. In fact, the stripping away of an inmate's identity, ritual humiliation and denying them human rights are rationalised on security grounds. It is interesting to note that resistance to the Nagle reforms by custodial officers, the union and the institutional administration, was, they argued, for security reasons.

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[126] *Ibid*, pp.95-6.

3.7.2 Report of the NSW Women in Prison Task Force

In 1985 the Women in Prison Task Force submitted its report to the Minister of Corrective Services. The report, in part, continued the work of the Nagle Inquiry, and, in part, it was to correct the lack of detailed investigation and attention given to women prisoners in the Nagle Report. The Task Force Terms of Reference included:

- Reviewing the appropriateness and adequacy of the prison facilities in NSW;
- To recommend to the Minister best practice custodial and non-custodial options for women offenders;
- To review the correctional services for women prisoners;
- To examine the present prison facilities and ascertain whether they meet with the special needs of women;
- To co-ordinate research and community consultation on a variety of policy areas;
- To examine and make recommendations on additional matters.[127]

The report considered the profile of women in prison and made recommendations for women on remand, drugs, pre-release programmes, alternatives to incarceration, Aboriginal and migrant women, conditions in prison including health services, accommodation and post-release services. I will only cover in any detail the areas of concern for this thesis: namely the profile of women in prison in NSW, health services, contact with children, drugs and accommodation.

The report states that NSW has the largest prison and remand population in Australia.[128] Moreover, women in NSW receive longer sentences and are more likely to be imprisoned for drug related reasons. These facts are not fixed or immutable; the report goes on to argue that imprisonment rates are socially constructed, produced by economic, social, political and legal processes.

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[127] Report of the NSW Women in Prison Task Force, *op cit.*

[128] NSW imprisons women at twice the rate of Victoria, for example. See p. 40 for more information.

> Women do not just "turn up" at the gates [the prison} – they have undergone a complex of processes prior to the imprisonment. In particular, their prior social or lifestyle history, especially the extent to which they might be drug-dependent on the one hand and the extent to which they might have been defined in relation to dominant familial and sexual structures and roles on the other, will be of significance. The combined effect of a range of police, welfare, legal and court processes and exercises of discretion will also significantly affect their chances of ending up in [here].[129]

3.7.2.1 Women and Drugs

The Task Force found that there were a disturbingly high proportion of women in gaol who had a history of drug and/or alcohol use. They reached the conclusion that prison was not appropriate for drug-dependent women. [130]

The adequacy of the programmes for drug-dependent women in NSW prisons was severely criticised by the Task Force. The detoxification programme consisted of a nurse interviewing the prisoner to determine whether she ought to be admitted to the Annex hospital to detoxify. Treatment varied from patient to patient depending on the type of drug the patient was withdrawing from, but generally symptoms such as vomiting, cramps, dehydration, etc., were controlled as necessary. Specific criticisms about the adequacy of the detoxification programme were described by the Task Force as 'numerous'. The Annex facilities were deemed inadequate. The two showers available could not be accessed by prisoners as the Annex dormitory was locked from 4.30pm until 8.00am. Unfortunately, the women did not stop vomiting during this time. The report states that nursing staff agreed this was a problem and had, in recent months, requested the showers be open for women to use.

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[129] *Ibid,* p.41.
[130] *Ibid,* p.79.

Women detoxifying and otherwise sick women were all placed in the Annex together. Prisoners complained about a lack of privacy – the women who were sick but not detoxifying complained about the agitated behaviour of the detoxifying women, and the detoxifying women craved privacy because of their symptoms.

Attitudes towards inmates by both custodial and medical staff were considered punitive by drug-dependent women patients.

3.7.2.2 Health Services

The Task Force reported that in relation to the provision of health services to women prisoners, the main criticisms made by the Nagle Report in the section on women prisoners had not changed or improved. They also note "the conditions of imprisonment are likely to exacerbate ... already existing [health] problems and that people in custody contract stress-related physical conditions at a dramatically disproportionate rate to a comparable population outside prison."[131]

Medical care was provided by only one doctor and one dentist and this was considered insufficient by the Task Force. Within the maximum security facility, at the time, health care was delivered in two separate units: the Annex, a generalist unit and Rose Scott, a psychiatric unit. Because of the lack of facilities, the units were designated 'dual function'. In practice this meant the Annex was used for general medical care and detoxification and Rose Scott was also used for punishment and

[131] *Ibid*, p. 175.

protection. The Task Force argues these "'dual functions' seem doomed to failure because of inherently contradictory needs and roles."[132]

A recurring issue noted by the Task Force was the conflict between custodial and health care requirements.

> Within the prison system, the provision of adequate health care is frequently frustrated by custodial and management requirements. For example, surveillance requirements restrict the movement of prisoners within the prison complex and hence severely limit access to exercise... Drugs of dependency which have been prescribed to women whilst at liberty are frequently not available in prison due to the nature of the prison environment and the limited choice of medical personnel. Escorts are sometimes unavailable when outside treatment is required. Custodial, security or punishment requirements often dictate the placement of women in the Annex or the Rose Scott Unit, to the detriment of the therapeutic and medical goals of these units.[133]

As with the Nagle Report, the Task Force found women prisoners highly critical of the medical service and the practitioners.

> Complaints include harsh and uncaring attitudes towards the women; excessive and inappropriate concern with the prison ethos of discipline, punishment and security; unsatisfactory treatment for minor medical ailments and *all* dental problems; excessive difficulty in getting major ailments recognized, diagnosed and treated; delays in treatment and difficulty in getting 'outside' referrals and escorts; and concern that doctor/patient confidentiality is not preserved (emphasis in original).[134]

The Task Force also noted that while, in theory, women could consult a doctor of their choice this practice was "negated in practice by informal prison veto and by the fact that prisoners are not covered by Medicare."[135]

They argued the following principles be the basis of their recommendations:

1. Health care provision must take precedence over all other considerations.

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[132] *Ibid,* p. 176.
[133] *Ibid,* pp. 177-7.
[134] *Ibid,* p. 177.
[135] *Ibid.*

2. Every prisoner has the right to the same range and standard of health care as any member of the community.
3. Health care requirements must take precedence over custodial requirements
4. Health care professionals working within prisons must be primarily accountable to the patients. They must treat their patients in their environmental context and change those factors which are detrimental to health.
5. The model for health care within prisons should reflect models in the wider community. For example, for non-hospitalised patients, a General Practitioner model – including confidentiality, doctor of choice, right to a second opinion – and ready access to specialist medical services and hospitalisation.[136]

Mental health issues were specifically addressed by the Task Force. They argued imprisonment increased inmates' emotional strain and stress. This situation was particularly true of women prisoners, because many lose the opportunity to care for their children. Moreover, the environment – including prison organisation and routine – causes feelings such as a sense of powerlessness, frustration and isolation. The necessary isolation from other prisoners further limits an inmate's ability to help, and be helped by, others.

The Task Force recommended altering prison practices to minimise emotional conflicts. It further recommended increasing the number of consultant psychiatrists and training prison officers in mental health issues. Psychiatrically ill patients were to be transferred to a psychiatric hospital. The Task Force noted that there were no programmes specifically for women with an intellectual disability, and recommended this be remedied. On the issue of self harm, the Task Force argued:"[S]elf mutilation should cease to be seen as a breach of discipline, requiring appearance before a

[136] *Ibid,* pp. 183-4.

Visiting Justice, and instead should be seen as an indication of the need for therapeutic intervention."[137]

3.7.2.3 Legacy of the NSW Women in Prison Task Force

The Task Force reiterated many of Nagle's recommendations, and further, made a number of recommendations about not only the conditions of women in prison, but the circumstances which ought to be taken into account when considering imprisonment. This included suggestions for changes to legal aid, policing, and decriminalisation of heroin.

In terms of Brown's criteria, the Task Force was less successful. While the Task Force was able to establish the truth with regards to the condition of women in prison, it failed to settle accounts and establish the stimulation for long term penal reform. Part of the reason for its failure to achieve the latter two criteria is that its recommendations went far beyond the purview of the DCS. Moreover, the report was submitted during a political and media led 'get tough on crime' campaign.

The task force did recognise important ethical problems with the delivery of health care to women in NSW prisons. Consistent with international and national declarations and codes the report argued that health care provision take precedence over other considerations, including security. It also argued for the primacy of the health care professional- patient relationship. The Task Force report considered health in its wider context. The report considered the social and political determinants of health by drawing attention to the life experiences women bring with them to

[137] *Ibid,* p.191.

prison. Moreover, the report recognised how the experience of being in prison exacerbated or even caused ill health.

3.7.3 The NSW Ombudsman's Report 1997

The Ombudsman's Report was in response to allegations made by inmates at the maximum security correctional centre and a Sydney Morning Herald journalist in 1994. These allegations included:

1. a sex-for-favours network;
2. a substantial increase in self harm by prisoners;
3. the theft of methadone from the clinic;
4. substandard medical, and psychological care of the inmates;
5. irregularities about one inmate's death and the failed suicide attempt of another.[138]

It must be noted that investigators did not find any evidence of a sex-for-favours network at the maximum security prison, nor were any of the other allegations upheld. It is worthwhile, however, discussing issues which relate to the delivery of health care. While this research considers the impact of context on heath care providers, this will be affected by how context impacts on the recipients of health care and the culture of prisons. The Moss report goes to address these issues.

3.7.3.1 Suicide and Self Harm

According to the *1997 Inmate Health Survey*[139] conducted by CHS, suicide is much higher in prison than in the general community as the prison population is more vulnerable.[140]

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[138] *Ibid,,* p.ii.
[139] Corrections Health Service, *Inmate Health Survey,* Sydney, 1997.

Self harm or mutilation is an intractable problem in prisons, and this is especially true in women's prisons. The Report notes:

> [T]he department's (DCS) statistics on reported incidents of self harm for 1994 reveal that 37 women committed acts of deliberate self harm by strangulation, 187 by slashing, four by overdose, three using a multiple method and one 'other' method. This totals 232 incidents involving actual injury to women. More than half of the total number of incidents of self harm resulting in injury in the correctional system – 232 of 415 – were committed by women prisoners (who, one should remember constitute approximately 5% of the population).[141]

3.7.3.2 Physical and Mental Health

The Ombudsman decided that the investigation into reports of sex-for-favours and high levels of self harm allegations should include not only DCS but also CHS. The Ombudsman's officers heard unsolicited negative comments about CHS by 32 of the 34 women interviewed. Below is a summary of their complaints.

- long delays getting appointments to see a doctor;
- delays in getting a specialist appointment;
- clinic staff unwilling to listen to problems;
- public discussion of medical problems;
- reluctance by the clinic staff to give sick certificates;
- waiting outside the clinic window in all sorts of weather and no privacy discussing problems.[142]

3.7.3.3 Medical Facilities and Services

In 1994 the maximum security facility clinic had been recently renovated. The hospital wing had six single rooms, offices, consulting rooms, and the dispensary. Patients would come to the dispensary or pill window to receive their medications or ask for a medical appointment. Urgent cases were bought into the Annex which contained three waiting areas. The Annex was an observation area for those patients

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[140] Butler, Y. Milner, L. *The 2001 New South Wales Inmate Health Survey,* Corrections Health Service, Sydney, 2003, p.101.
[141] NSW Ombudsman, *op cit,* p.50.
[142] *Ibid,* p.155.

not sick enough for hospitalisation but too sick to return to their cells. The flow of inmates within the Annex is controlled by a custodial officer.

Between 9-10am the prisoners could attend the pill parade.

> The women wishing to attend pill parade went to work first and requested to attend the clinic from there. They then queued on the balcony outside the pill window to see a nurse... Women who are given permission to be 'sick in cell', ie too unwell to go to work, but not sick enough to be admitted to the annexe (with influenza for example) are given a certificate and returned to their cells. The clinic nurses are able only to give a certificate for one day at a time, so if a woman is unwell at this level for a number of days but had not been given a doctor's appointment, she must present each morning for renewal of her certificate.[143]

General practitioner clinics were held four days per week and a practitioner from the Aboriginal Medical Service (AMS) held a clinic each fortnight as did the obstetric and gynaecology clinic. A women's health nurse was appointed in 1993 to attend to routine Pap smears and run a Sexually Transmitted Disease clinic.

Specialist services were available at the two most geographically local tertiary general public hospitals.

3.7.3.4 Clinic Window and Waiting Room

Inmates complained to the officers of the Ombudsman that they had to queue at the pill window – the area was not covered – despite the weather conditions. A further complaint was the lack of privacy. The latter claim was disputed by CHS. They maintained:

> [I]t was never envisaged the private concerns or observations would be conducted at the pill window, rather a screening system to limit those waiting in

[143] *Ibid.*

> the clinic purely for routine matters as to receive medication, to make an appointment. Thus nothing more than establishing the need for the basic request is discussed. In this regard it may be necessary to ask some relevant questions especially if a priority needs to be set on the day. However, if privacy is required the inmate sees the nurse in the clinic.[144]

Moss however, argues:

> [I]n relation to the main morning parade... and despite CHS continuing to assert that the need for privacy does not have to be demonstrated, only requested, it is difficult to see how a woman would both be required to discuss her medical problem in order to indicate her need for privacy.[145]

3.7.3.5 Delays

The Ombudsman's officers examined a number of medical files, with the permission of the women, in order to establish whether undue delays occurred for treatment. While delays did occur, most were not unreasonable. Delays in receiving treatment from outside the prison system did occur: and these occurred for two main reasons. The first problem related to the hospital system external to the prison. Specialist appointments were difficult to obtain, with many hospital departments triaging patients. The second problem related to a lack of escorts.

> CHS staff asserted that there have been difficulties in keeping specialist appointments, not least, my officers were told, because of lack of reliable custodial officers to supervise two such appointments each week day.[146]

3.7.3.6 "Tell Someone Who Cares"

The Ombudsman found the most common complaint by inmates was the uncaring and combative attitude of CHS nursing staff. Not only did this complaint come from the women prisoners "but also by a number of people with relevant professional

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[144] *Ibid*, p. 166.
[145] *Ibid.*
[146] *Ibid*, p.172

expertise; the latter including psychologists, drug and alcohol workers, current and ex-CHS staff."[147] This problem was noted in the Nagle Report. One ex-CHS staff member argued:

> they (the nurses) took on the attitudes of custodial staff and became exploitative of weakness thereby compromising basic issues of care... She did, however, make the point that the nurses were under a lot of pressure... including living with attitudes that if they were any good at their jobs they would be looking after deserving people, not criminals.[148]

A further problem was the poor working relationship between CHS and DCS staff, including psychologists and alcohol and other drug (AOD) workers.

> AOD workers, said, for example, that they would go to the clinic to discuss their methadone clients and be told to go away. A psychologist spoke about having negotiated at length with a woman who had slashed her own throat, eventually talking the woman into going to the psychologist's office from where they rang the clinic. The clinic staff would not see the woman unless she came to the clinic.[149]

Correctional officers also criticised CHS clinic staff:

> officers expressed the level of health care to inmates was "appalling"; that the clinic was too short staffed to properly assess the condition of the women or to provide adequate treatment.[150]

3.7.3.7 Psychiatric Care

Women in need of acute psychiatric care could be placed in the segregation and therapeutic unit then transferred to the prison hospital located within a male correctional facility, or be admitted to the acute ward at the nearest psychiatric hospital. There appeared to be problems with all of these facilities.

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[147] *Ibid,* p.175.
[148] *Ibid,* p.177.
[149] *Ibid,* p.178.
[150] *Ibid,* p.179.

The Crisis Support Unit at the prison hospital had limited access for women – only two at any time – and the unit catered for suicidal patients only. Sending women to the prison hospital was problematic for several reasons, not the least being the women patients could interact with male inmates. Moreover, the hospital seemed reluctant to take women patients and the Ombudsman's officers reported the process was difficult and only happened "if enough fuss was made".[151]

The public psychiatric hospital was supposedly available for both voluntary and involuntary admissions from the maximum security prison. Patients being sent to the public hospital were psychotic and suicidal. Psychiatrists working at the maximum security prison reported several problems with access to the public psychiatric hospital which impacted on the proper and timely treatment for patients. The first was long delays:

> [I]n principle, [the] hospital makes five beds available for female prisoners. But these five beds may be already full; even if they are not, the bureaucratic delays in transferring an inmate out of jail can be up to 14 weeks! For a person who is suicidal or suffering from an acute psychotic disturbance, this delay is tantamount to official medical negligence.[152]

The second was the attitude of the staff at the public hospital. CHS believed hospital staff held negative attitudes to inmates.

Caring for profoundly mentally ill patients in the maximum security correctional centre was also problematic.

> [T]he patient ... is kept in segregation ... with little medical supervision, let alone psychiatric supervision, and in extremely depressing environment that even an animal would be depressed in... There are many inmates who would be far better cared for in a psychiatric setting but who end up in these units often

[151] *Ibid,* p.188.
[152] *HREOC Inquiry*, p.778, 1991 cited in *Ibid,* p.186,

being physically restrained and isolation being used as a form of control. The prison officers are often the ones who end up with the crisis on their hands and in need of psychiatric and medical back up when there is little or none available.[153]

3.7.3.8 Staffing and Staff Roles

Moss noted problems with patient care, particularly psychiatric care, because of the division of labour between CHS and DCS. Women were cared for by CHS personnel (psychiatrists and psychiatric and general nurses) and DCS staff such as psychologists and prison officers.

The psychiatrist's role substantially involved assessing the mental health status of a patient, devising treatment plans and writing court reports. The Report cites comments by a consultant psychiatrist about his role;

> [H]e did not spend long with women where it was only a matter of assessing/readjusting their medication – perhaps 10 or 15 minutes. His comment was, because of time pressures, he was not able to spend as much time with these patients as he did in his private practice, although there might be just as much need... he would usually have eight to ten women on his clinic list for a session lasting three hours. He was regularly unable to even see more than two-thirds of his list.[154]

According to the then Chief Executive Officer of CHS, Dr Brown, counselling patients, if necessary, was the job of the psychologist, not the psychiatrist. The psychologists then, were responsible for counselling patients, managing some suicidal patients, and producing patient management plans. The Ombudsman notes that they also write reports:

> on which depend the progress of an inmate through the correctional system. The latter function is presumably why these health professionals are employed

[153] NSW Ombudsman *op cit, p.186.*
[154] *Ibid,* p.194.

> by the Department of Corrective Services and not the Corrections Health Service.[155]

The psychiatric nurse dispensed medication, provided counselling to patients, supervised or tended to their nutritional and hygiene needs, liaised with medical and custodial staff, organised admissions and discharges from the unit, kept relevant medical records and monitored people in the general gaol population with a developmental disability. As Moss points out, there was no explicit requirement for them to care or supervise any woman in the safe/dry cell.[156]

Given the patient population in the therapeutic unit – often patients with a personality disorder and those who self harm – effective long term counselling was problematic. Both psychologists and the nurses claimed they spend most of their time responding to crises, and that continuity of care was difficult.

> All these professional people agreed that inmates were really only seen by them when the inmate was in crisis; they were able to provide very little ongoing support or assistance.[157]

The liaison difficulties meant patients could either miss out on treatment or be over-treated. The Ombudsman reports tensions between custodial staff and psychologists, and between nurses and psychologists. She refers to the difficulties of having two sets of patient notes for the same patient – one for CHS staff the other for DCS staff. Inter-disciplinary rivalry was evident. Psychologists could not refer patients directly to psychiatrists; the patient has to be first assessed by a nurse and then referred if necessary.

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[155] *Ibid,* p.194-5.
[156] *Ibid,* p.196.
[157] *Ibid.*

In the final report, the Ombudsman reported the implementation of a new management structure has solved many of the liaison problems cited above.

3.7.3.9 Drugs

Drugs are a huge problem in prisons – both licit and illicit drugs. Moss reports:

> [C]ertainly the drug culture in [the prison] is a significant factor in the violence in the prison. Women are assaulted for drugs they are believed to be holding; standovers for drugs are not uncommon; and then there is the violence which arises out of an enmeshed social structure based on the giving and receiving of drugs.[158]

Women in prison are more likely to take psychiatric medication and be on a methadone program than women in the general community. Inmates had made a number of complaints about the administration of methadone. Methadone was dispensed in the morning, however at the request of the then Governor, this was changed to the afternoon. The reason for the change was because the women were drowsy while at work. The Governor also argued the whole prison routine ought not to be dictated by the women on the methadone program. CHS was consulted and the programme changed from the morning to the afternoon. The policy was changed back however, because some inmates were not only taking methadone in the afternoon, they were taking illicit drugs also.

> It became evident that some inmates were irresponsible and consumed **illicit drugs** at night, the management of CHS decided the dosage time should revert to the morning (emphasis in the original).[159]

[158] *Ibid,* p.233.
[159] *Ibid,* p.219.

3.7.3.10 Self Harm

The lack of a team approach to inmate care had, according to the Ombudsman, hindered the ability to develop a broad strategy to cope with the complex problem of self harm. Consequently a new behavioural management plan was implemented to deal with self-harm. As a consequence of this plan, the therapeutic goal was psychological rather than medical and thus the responsibility of DSC staff.

> At the threat of, as well as following actual incidence of self harm, the woman is put into a safe cell for a period of up to 24 hours. During this time she receives any necessary medical attention, but nothing more. After that period she is interviewed by a psychologist and attempts are made, where possible, to address the problems she is reacting to. This does not include acceding to requests for transfers within the prison, for example, the refusal of which has been cited by previous management as a common reason for cutting up, but rather focuses on psychological or emotional problems.[160]

3.7.3.11 Legacy of the NSW Ombudsman's Report

It is not appropriate to analyse the Report by the three key criteria suggested by Brown (establishing the truth, settling accounts and stimulating reform).[161] Reports from the Ombudsman arise from complaints rather than from governments requiring advice on a socially difficult problem.

Moss, in her recommendations, found clear improvements to the condition of women in prisons. Given this, she decided it would not be appropriate to make formal findings against DCS or CHS. Moss does make six recommendations relating to the delivery of medical and psychiatric care. These include review of complaints policy; the proper resources to be provided to the therapeutic unit; restructuring of the mental health teams and better liaison between staff caring for patients with a mental health

[160] *Ibid,* p.289.
[161] Brown, D. *op cit.*

issue; provision of an awning over the pill window and attention to the recruitment of well qualified nursing and medical staff.

The report gives some indication of the culture of prisons and prisoners. Moss found evidence of a culture of prisoner violence, both self- and other-directed. The prison drug culture significantly contributed to other-directed violence. The report confirms issues expressed in the literature on prisons, raised in the previous chapter. The issues of acculturation and dual loyalties were evident in complaints about nurses assuming custodial attitudes, and changing health care practices for custodial reasons (methadone programme and safe cell practice).

The Moss report makes comment on the professional and ethical standards inherent in the health care practitioner-patient relationship. Complaints about health care practitioners' disrespectful attitudes and behaviours towards patients, and breaches of confidentiality and privacy indicate ethically and professionally compromised practitioner-patient relationships.

The tense relationship between correctional and health care staff, apparent in the Ombudsman's report, was also reported in the literature cited in chapter 2. The Ombudsman found this tension compromised patient care. Patient care was also compromised by custodial practices, particularly with regards to escorting patients to hospitals and medical specialist appointments outside the prison complex.

3.7.4 Issues Arising from the Inquiries

In the previous chapter I argued that while consensus has not been reached on the best theoretical approach to ethics, it is generally, if not universally, agreed that health care is a moral and social good. This makes the delivery of health care, the role of health care practitioners and the practitioner-patient relationship morally important. The various general international and national declarations and codes and those which relate specifically to prisoners make it clear that providing health care to prisoners is a moral obligation and one that is not extinguished by incarceration in a correctional facility. Prisoners ought to have access to health care and it ought to be of an equivalent standard to the rest of the community. Nagle makes this point explicitly when he argued inmates maintain all human rights with the exception of a right to liberty and rights associated with said liberty. Moreover, the health care practitioner-patient relationship is bound by the same ethical obligations which obtain outside the prison context.

The evidence from the three inquiries discussed above indicates women prisoners did not receive the same standard of health care as the general community. Firstly, the health facilities were inadequate. The Nagle Report, the NSW Task Force and the Ombudsman's Report were all critical of the lack of adequate health care facilities for women. The arrangements for dispensing medication and arranging medical appointments were also criticised by the inquiries. This arrangement had implications for patient autonomy, confidentiality and privacy.

The declarations and codes specific to prisoners make it clear that health care and treatment ought to have priority over all other concerns, including security. All three

inquiries, but particularly Nagle and the Women's Task Force, were critical of the subordination of health care to security concerns. Nagle specifically argued that one reason for the lack of appropriate medical care to prisoners was that all considerations, including medical ones, were subordinated to security demands. The Task Force also made it clear that the delivery of timely and appropriate medical care had been hampered by custodial requirements. They go on to assert that health care needs must be primary and take precedence over custodial requirements. The tension between custodial and health care concerns discussed in the literature was played out over the care and treatment of mentally ill patients as the officers reporting to the Ombudsman make clear. While work has been done by both groups to improve communication for the good of the patient, the demarcation between roles and differing professional loyalties makes this goal problematic.

All three inquiries were critical of the attitudes of both custodial and health care staff to prisoners. All prisoner-specific declarations and codes assert that prisoners must be treated humanely and with respect. Nagle and the Task Force were particularly critical about the poor staff attitudes to inmates. The Ombudsman's Report explicitly examined staff attitudes to patients, and, while much less strident in its criticism, urged CHS to recruit experienced medical and nursing staff.

Access to appropriate health care and community equivalence are mandated in prisoner-specific declarations and codes. This becomes highly problematic when health care practitioners cannot appropriately treat their patients because their condition is caused or exacerbated by incarceration. The idea that the prison environment is detrimental to the health of prisoners resonates through all the reports.

For Nagle, it included *inter alia* the lack of appropriate programs, specifically detoxification programs for drug and alcohol addicted women. He also recognised that prison time was particularly problematic for women. The Task Force also recognised that spending time in prison could be bad for women inmates' health. Indeed the Task Force strongly argued that drug rehabilitation should not occur in prison as the aims were antithetical. The reasons behind self harming behaviour described in the Ombudsman Report also address this issue.

Goffman and Davies argue that the goals of total institutions, particularly in terms of security and surveillance, not only provide the rationale for all activities in such institutions but pervade all activities and attitudes. The evidence in the inquiries supports their thesis.

3.8 Conclusion

The modern prison context is a complex and total institution. Correctional centres not only serve the purpose of punishing inmates by depriving them of their liberty, they also protect society and transform or reform prisoners. Theories of total institutions discussed in this chapter are clearly important in understanding prisons as total institutions.

Historically, analysis shows women prisoners were viewed as problems and to some extent this is still the case. According to the inquiries, custodial authorities and health care providers have found accommodating women inmates difficult. This includes their health care, social, educational, vocational, and criminogenic needs.

International and Australian research[162] show that women, because of their gender and social roles, experience imprisonment in a different and more complicated way than men. Moreover, their relative small numbers makes providing facilities, staff and services to and for them particularly problematic.

In the next chapter I will discuss the methodology of this thesis. The following four chapters will be an examination of how doctors and nurses experience providing health care to women in two prisons. Specifically, it will consider how the prison context impacts on the presumptive ethical and professional obligations of health care practitioners. The aims of this research are:

1. To understand how the prison context impacts on ethical and professional health care practice via examination of health care professionals' experience;
2. To understand the limits and possibilities of clinical freedom in confined contexts;
3. To examine the adequacy of ethical principles and Codes of Ethics for explaining or describing the ethical obligations of health care practitioners working in the prison context.

[162] See Byrne, M. Howells, K. *op cit,* and Johnson, H. *op cit,* respectively.,

Chapter Four: Participants, Materials, and Methods

4.0 Synopsis

In this chapter I will outline basic information about the participants, materials and methods, including the study design, research methods, and selection of the correctional centres, the study population and data analysis.

4.1 General approach adopted in this thesis

The professional experiences of doctors and nurses who work in correctional environments are under-represented in the academic literature, particularly on ethical issues facing clinicians. Corrections Health Service also lacks systematic research-based evidence about ethical issues which commonly face their staff. The NSW Independent Commission Against Corruption (ICAC)[1] recommends that identifying and understanding the prevailing ethical culture in an organisation is an important prerequisite for ethical development. This evidence is also required to assist planning of education and staff support. This research aimed to reduce these deficiencies in existing knowledge.

4.1.1 Research Methods

The literature review discussed in the previous chapter found few published articles concerning factors influencing nursing and medical practice in Australian prisons.

[1] Zipparo, L. *Ethics: the key to good management,* NSW Independent Commission Against Corruption, Sydney, 1998.

While some articles and texts discuss professional and ethical issues, none focuses specifically and entirely on ethical issues. Because of the paucity of previously published research, I propose to take a qualitative approach in this study to gather exploratory information about the impact of context on the nature of ethical and professional issues confronting CHS personnel working in women's prisons. Qualitative approaches are "concerned with the meanings people attach to their experiences of the social world and how they make sense of that world."[2] Given this study is about clinicians' perceptions, a qualitative approach seemed apposite. Pope and May argue a key strength of qualitative research is that "it studies people in their natural setting".[3] Thus a qualitative approach was considered the most appropriate to study how clinicians experienced and make sense of a highly specific context.

The qualitative methods used in this research study were in-depth, semi-structured interviews and, to a lesser extent, field observation. Face to face interviews were employed in preference to other data collection methods. As Rice and Ezzy point out, the advantages of interviews include: discovering the subjective meanings and interpretations people give to their experiences, the fact that people usually find the experience rewarding and, most importantly, the fact that participants are more prepared to discuss sensitive matters face to face and without the direct presence of their peers.[4] Another reason for interviewing face to face was that this research was about context. It was important, therefore, for the interviews to be conducted in prison, which is the work context for these health care practitioners. Face to face interviews also allowed for a measure of field observation. While field observation

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[2] Pope, C. Mays, N. Qualitative methods in health research, in Pope, C. May, N. (eds) *Qualitative research in health care,* 3rd edn, Blackwell Publishing/BMJ Books, Malden, 2006, p.4.
[3] *Ibid.*
[4] Rice, PL. Ezzy, D. *Qualitative Research Methods: a health focus,* Oxford University Press, South Melbourne, 1999, p.67-68.

contributes in only a small way to the data, I was able to get a sense of the prison context including security arrangements, view the health care clinics within the prisons, and observe some (non-confidential) interactions with patients and health care practitioners, and correctional staff.

Other types of data collection were rejected as inappropriate. Questionnaires, for example, are often quicker, and permit anonymity of respondents, but are only useful where enough knowledge exists to permit the framing of appropriate and relevant questions. Interviews are more useful in situations, such as this one, where existing knowledge is too sparse to permit the framing of such questions.

The data were analysed thematically. Thematic analysis is the most common and more accessible approach to data analysis in the social and health sciences.[5] It "does not rely on the specialized procedures of other means of analysis such as grounded theory methodology, discourse analysis, and semiotic analysis,"[6] but "seeks to unearth the themes salient in a text at different levels".[7] Moreover, it is an appropriate method of qualitative analysis where research is exploratory.

4.2 Selection of Correctional Centres and Population

The two sites in which this research was carried out were chosen for four reasons. Firstly, little research has been conducted specifically in women's prisons. This

[5] Holstein, JA. Gubrium, JF. Active Listening, in Silverman, D. (ed) *Qualitative Research: theory, methods and practice,* Sage Publications, London, 1997 and Pope, C. Ziebland, S. Mays, N. Analysing qualitative data, in Pope, C. May, N. (eds) *Qualitative research in health care,* 3rd edn, Blackwell Publishing/BMJ Books, Malden, 2006, p.69.
[6] Schwandt, TA. *The Sage Dictionary of Qualitative Inquiry,* 3rd edn, Sage Publications, Los Angeles, 2007, p.291.
[7] Attride-Stirling, J. Thematic networks: an analytic tool for qualitative research, *Qualitative Research,* 1, 2001, p.387.

research aimed to help correct this deficit. Secondly, I wanted to explore the experiences of doctors and nurses working in contexts which included maximum, medium and minimum security facilities. In this way I could explore the impact of different levels of security on prison health care practice and practitioner-patient relationships. The two women's prisons selected included all three security classifications.

Thirdly, it is likely that the gender of the patient (and the health care practitioner) will influence the practitioner-patient relationship. Choosing women's prisons as opposed to including both men's and women's prisons meant that I was able to minimise the impact of gender on the practitioner-patient relationship. Finally, women's prisons were chosen as the site of this research because I hoped that by understanding the impact of context on the ethical and professional responsibilities of health care practitioners, women's health care could be improved.

I acknowledge that this study could have been strengthened by interviewing other groups, including prisoners and DCS staff. The study was restricted to doctors and nurses because the thesis examined the perceptions of these health care professionals.

4.2.1 Maximum Security Correctional Centre

The maximum security correctional centre in which the research was undertaken is described by DCS,[8] and as already stated in chapter 3, is a combined maximum, medium and minimum security institution for females. It is the principal prison for

[8] New South Wales Department of Corrective Services, *Correctional Centre: Maximum Security Correctional Centre*, available at http://www.dcs.nsw.gov.au/correctional/main.asp accessed 4.3.2003.

women in NSW. Women prisoners were transferred to the maximum security correctional centre in 1970 and since that time it has undergone two reorganisations. According to the DCS website, the Centre holds a total of 235 inmates "and is divided into 12 living units, a protection/segregation area, induction unit, hospital annex, and accommodation for both sentenced and unsentenced inmates and various special program units."

Services for the inmates comprise educational programs including: Certificates in General Education, English Language Literacy, Vocational Education and Training, Information Technology, Communication Skills and Art. Courses offered include painting and decorating, word processing, computers and small business management. Special programs are also offered to the inmates at the facility which comprise of AIDs awareness, conflict resolution, anger management and harm minimisation. The prison's main industry is assembling airline headsets.

The maximum security correctional centre had a staff of 200 consisting of custodial officers (169), welfare officers, psychologists, drug and alcohol workers, mental health nurses, probation and parole officers and screening and induction officers.[9]

4.2.2 Minimum Security Correctional Centre

The other facility in which this research was carried out was originally, in 1914, a prison farm for young offenders. Its purpose was to provide vegetables and farm produce to government institutions. In 1916 its control was transferred to the

[9] New South Wales Department of Corrective Services website Http://www.dcs.nsw.gov.au/offender_management/offender-management_in_cus... accessed 14.12.2006.

Department of Agriculture. Juvenile offenders still worked on the farm until they were released. This arrangement lasted until 1917 when control was handed back to the Comptroller-General of Prisons as a place of detention.[10] In the 1930s the farm prison introduced dairying. The farm was remodelled in 1951 with more secure buildings constructed. In 1994 it was designated a correctional centre for women. The centre can accommodate 118 inmates. A purpose built house provides accommodation for inmates and their children. The total staff comprises 61 persons, 35 of whom are custodial officers. [11]

Education opportunities are similar to the maximum security correctional centre but include some different opportunities, specifically horticulture. Courses include forklift licence, tractor operation, hospitality, and life skills. Special programmes are offered and designed to assist inmates prior to release. Prisoners also work in the dairy.[12]

4.2.3 Health care - Maximum Security Correctional Centre

Health care is delivered in the clinic and attached Annex, a six bed hospital ward. Patients visit the pill window for routine medications including methadone, analgesics such as Panadol and to make medical and nursing appointments. Patients waiting for their medical or nursing appointments are kept in what patients call 'the cage'. There is an obvious custodial presence in the form of correctional officers. Patients are seen by the health care staff in the clinic rooms.

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[10] Nagle *op cit,* Vol 3 p.140.
[11] New South Wales Department of Corrective Services, available at http://www.dcs.gov.au/correctional accessed 4.28.2003.
[12] New South Wales Department of Corrective Services website *op cit.*

The patient services available on site are: registered nurses, mental health, women's health, public health, psychiatric, oral health, optometry and physiotherapy. At the time of interviews, patients in need of physiotherapy services were sent to the local public hospital. I also noted Aboriginal health care, ante-natal care and dental services were provided.

4.2.4 Health care - Minimum Security Correctional Centre

The minimum security correctional centre's health care facilities were superior to those at the maximum security facility. The clinic was relatively new and purpose built. Security arrangements were less evident at this correctional centre. No 'cages' were necessary, for example. A correctional officer was sometimes present at a desk inside the clinic. As with the maximum security facility, medications were dispensed via the pill window and medical and nursing appointments could be made there also. Consultations took place in consulting rooms in the clinic.

The patient services available on site are: registered nurses, women's health, public health, psychiatry, oral health, general practice, optometry and liver centre. As with the maximum security facility, Aboriginal health care, ante-natal care and dental care were provided.

4.3 The Study Population

CHS employs doctors and nurses, dentists and dental nurses at the clinics at both the maximum and minimum security correctional centres. This research was restricted to

medical practitioners and registered nurses. Medical staff employed at the maximum security clinic and Annex included consultant psychiatrists and a psychiatric registrar, a senior consultant responsible for women's health, doctors employed by the AMS (the Koori doctors) and general practitioners, usually with experience in family planning/women's health. The nurses employed include the Nursing Unit Manager of the clinic, and those with expertise in mental health, women's health, public health, and general nurses. Nurses also staff the Annex. These health care professionals cared for a fluid and revolving population of 301 prisoners, when the study was conducted.

Health care employees at the minimum security correctional centre hold similar positions. Thus there are consultant psychiatrists, a psychiatric registrar, Koori doctors, and general practitioners. The nurses include the Nursing Unit Manager and general nurses. Some of the medical and nursing staff work across the sites, including the senior consultant and women's health nurse. At the time of the study, there were 192 prisoners incarcerated at this facility.

4.3.1 Access to the study population

I worked collaboratively with senior members of CHS on the research project. Prior to ethics approval the project needed the support of CHS for several important reasons. By supporting the project, CHS gave me access to their staff. This support included giving me permission to interview CHS staff during their working hours and providing me with appropriate venues for the interviews. Moreover, senior staff at CHS placed Participant Information Statements in the clinics of both the dedicated women's correctional centres. The senior staff, who gave support for the study and

assisted me in other important ways, were not interviewed for this research. I am an academic and registered nurse but have never been employed by CHS. My primary role was as the researcher/interviewer but I also brought to the role my knowledge and experience of working in clinical settings.

4.3.2 Ethics Approval

The ethics protocol was submitted and approved by The University of Sydney Human Research Ethics Committee and The Corrections Health Service Human Research Ethics Committee. It is my understanding that the protocol was not required to be submitted to the Human Research Ethics Committee of DCS because the research did not involve inmates, however, the protocol was informally sent to this committee. They had no ethical objections to the research.

Apart from ethical approval, I was required to have security clearance to enter the two correctional centres. DCS was responsible for undertaking the rigorous security check and subsequently I was provided with security clearance.

4.3.3 Sampling

Twenty five registered nurses and ten doctors were employed by CHS in NSW women's prisons during the data collection phase of this research. While all nurses and doctors were invited to participate in this research, it was decided to interview both doctors and nurses from each site until thematic saturation was reached. 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 me to form some general conclusions. The second was to ensure verification of possible effects of profession

on ethical dilemmas by having practitioners in each professional stratum at each correctional centre.

4.3.4 Recruitment

Participant Information Statements were placed at the two clinics involved in the research. CHS clinical staff were informed that the research was approved by CHS and the interviews would be carried out within work hours. Interested participants were invited to contact me by telephone at The University of Sydney and arrange an interview at a time convenient to them. The majority of the participants were interviewed in a private room at their work venues; however, two participants – one doctor and one nurse – elected to be interviewed at The University of Sydney in my office.

4.3.5 Location and conduct of interviews

Because context matters in this thesis, I will provide a detailed description of the location and conduct of the interviews in this section. As previously stated, the majority of the interviews were conducted at or near the two health clinics within the correctional centres. Interviews were timetabled to fit into the work schedules of participants. When a potential participant contacted me, I would answer any questions and schedule an interview at their convenience and at a place suitable for them. Five of the six interviews at the maximum security centre were completed prior to any interviews at the minimum security correctional complex.

At the maximum security correctional centre, after producing my security clearance and having my appointment at the clinic verified, I was accompanied by a correctional

officer to the clinic. I was then escorted with the person I was to interview to a private room in a nearby venue. The venue altered due to room availability and preference of the person being interviewed. Two participants from this prison elected to be interviewed in my office at The University of Sydney. In one case this was for convenience; the person interviewed resided close to the university campus. In the other case, the participant did not want other CHS personnel to know of their participation in the study.

A consulting room at the clinic at the minimum security correctional centre was used for all interviews. After checking my security clearance, I was allowed to proceed to the clinic without being accompanied by a security officer.

After introducing myself, explaining the purpose of the research, participants were asked if they would like me to answer any further questions. If they were happy to proceed with the interview, a consent form was signed by the participant and, as required by CHS's Human Research Ethics Committee, this signature was witnessed by another person (other than the interviewer).

The interview questions were formulated in consultation with an expert in interview question design.[13] The interview questions included structured and semi-structured questions. Structured questions included demographic information and permission to audio-tape 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

[13] The interview questions are included in Appendix C.

events of ethical significance related to their work context: one which was resolved to their satisfaction and one which was not. Participants were asked specific questions about the two events, for example who was involved, why it was an ethical issue for them, would they do anything differently if the same or similar event occurred, and what they learned from the experience. If participants were unable to describe two ethical events they were asked to describe ethical issues which arose in the context of their work. Approximately half of the participants were able to describe two events; all but one participant discussed ethical and professional issues related to their work. All participants were asked whether they considered ethical issues arose because of the prison context. Questions were also asked to clarify certain issues I was unfamiliar with, particularly those specific to the prison environment. For example specific places or policies such as safe cell and sight and sound required clarification.

The interview questions were not piloted because of the small population available, however, they were designed in consultation with senior medical and nursing personal at CHS.

4.3.6 Basic information on participants

Participant characteristics are described in the table below. They are categorised by occupation, correctional centre and experience in the correctional system. Experienced practitioners are those who have more than three years experience working for CHS. In the main, the interviews lasted for an hour. For convenience I have rounded these to the nearest 15 minutes. In three cases the interview went for more than one hour, and in one case it went for considerably less. The gender and speciality of the participant clinicians is withheld due to concerns about

confidentiality as it would be very easy to identify participants if their position were to be disclosed.

Table 1 Basic Information about Participants

Occupation	Correctional centre	Experience	Length of interview
Nurse 1	Minimum Security	experienced	1 hour
Nurse 2	Minimum Security	experienced	1 hour
Nurse 3	Minimum Security	inexperienced	1 hour
Nurse 4	Minimum Security	inexperienced	45 minutes
Doctor 1	Minimum Security	experienced	1 hour
Doctor 2	Minimum Security	inexperienced	15 minutes
Doctor 3	Minimum Security	experienced	1 hour
Nurse 1	Maximum Security	experienced	1 hour
Nurse 2	Maximum Security	inexperienced	1 hour 15 minutes
Nurse 3	Maximum Security	experienced	1 hour 30 minutes
Doctor 1	Maximum Security	experienced	1 hour
Doctor 2	Maximum Security	experienced	1 hour 30 minutes
Doctor 3	Maximum Security	inexperienced	1 hour

4.4 Treatment of data

4.4.1 Transcription of Audio Recordings

All data were audio recorded with the permission of the participants. Audio tapes were transcribed either by the researcher or an experienced transcriber who signed a confidentiality agreement.

4.4.2 Editing, Presentation and Storage of Interviews and Transcripts

All transcripts were edited to ensure they were correct. Identifying names were coded according to occupation, the security classification of the correctional centre and by interview number: nurse, maximum security, interview 1, for example. The master file which identified the participant with their code has been destroyed for reasons of confidentiality. Only coded copies of the complete interviews were available to persons cited on the ethics protocol approval.

All original data are stored on a password protected computer available and located at The University of Sydney. Hard copies of the interviews are stored in a locked filing cabinet at The University of Sydney. When working on the data at another venue, my home for example, the hard copies were locked in a filing cabinet after use.

4.4.3 Coding categories for analysis

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 reread for the new themes.[14] After all the data were coded, related themes were grouped together under increasingly abstract, major themes. The coding tree which developed includes six major themes and related sub-themes. After establishing these major or cluster themes and related sub-themes, the data were then coded using NVivo7. The results chapters are organised along the same lines as the coding tree.

[14] Rice, PL. Ezzy, D. *op cit,* p.198.

4.4.4 Reporting of Data

The extracts from the transcripts are reported verbatim and attributed to participants as identified in Table 1 (for example, Nurse 1, Minimum Security). Where necessary the researcher/interviewer will be identified as KW in reporting the data.

Chapter Five: Health Care Practitioners – Ethical and Professional Virtues, Values, Standards and Feelings

5.0 Synopsis

In this chapter I will outline the results of one of the central themes of this thesis: the ethical values, virtues, standards and feelings articulated by the participant health care professionals and the way in which they were eroded or changed by the prison context. The chapter is organised into firstly, ethical values and virtues followed by professional standards and values and feelings. The division of concepts into ethical and professional is somewhat arbitrary: being impartial for example could be either a professional virtue or considered under the ethical principle of justice. I have divided the concepts according to the meaning attached to them by participants. Therefore if impartiality is spoken about in the context of a professional obligation I include it under the heading professional standards and values. Finally, I will report how participants felt about caring for incarcerated patients. I will show that, in the main, practitioners working in the prison context were unable to fulfil their ethical and professional obligations to patients because health care concerns were subsumed or subverted by custodial concerns. This was a distressing and frustrating experience for clinicians as too was the experience of caring for women prisoners who were violent and unpredictable.

5.1 *Ethical Values and Virtues*

Discussion of ethical values and virtues occurs in the order of importance for the clinicians interviewed. Before this, however, I will report how clinicians spoke about the importance of ethical and professional values to their practice, how they learnt about such values and provide a table reporting on issues clinicians felt important to their practice in the prison context.

5.1.1 Ethics

Ethics, our standards of right and wrong, and the ethical values held by health care professionals are centrally important to health care practice. This is evidenced in professional codes of ethics and the high standard of professional behaviour expected by the general public. All practitioners were asked about whether ethics were important in their clinical practice in the correctional setting. If they responded in the affirmative, they were asked which ethical principles they considered important. Participants were further asked to identify the source(s) through which they learned what constituted 'ethical practice' in their professional and/or personal lives.

On this last point, practitioners said they learned about ethics from a variety of sources, including family and home life, personal values, at university or during hospital training, and for many, working in health care institutions. Therefore, practitioners reported they that learnt about ethics through processes of personal and professional socialisation.

> **Nurse 2, Minimum Security**: I think it is something that you absorb through practice.

Doctor 3, Maximum Security: That was at university, and then working as an intern, and then we just have ethical issues as part of our training. Ethics is a big part of our training program.

Doctor 3, Minimum Security: I think it is something you learn from childhood on and carry through you whole life. You learn about it at University... just a developing thing as you go along.

The responses to the question 'what ethical principles and values are important to your practice' included many of the usual bioethical principles. Table 2 lists the espoused values. Espoused values are the values people name when asked specifically about their ethics/values. By referring to participants' espoused values, I am not suggesting that their practice is, or is not for that matter, consistent with these values, or that there are consistent meanings or understandings about the concepts between practitioners. It is worth noting, however, that not all the espoused values were evident or centrally important in the narratives of the practitioners interviewed. It is also worth noting that the nurses interviewed were more likely to consider codes of ethics and legal issues of ethical importance.

Table 2 Ethical values espoused by practitioners

Participant	**Ethical values**
Doctor 1, Minimum Security	Being non-judgmental, advocacy, fairness
Doctor 2, Minimum Security	Confidentiality, patient care, review
Doctor 3, Minimum Security	'Do unto others', honesty, confidentiality, right of prisoners to health care, privacy, equivalence of care
Nurse 1, Minimum Security	Best interests of the individual, maintaining standards, following protocols
Nurse 2, Minimum Security	Following codes of conduct, not being corrupt, harmonious staff relations

Nurse 3, Minimum Security	Consistency, fairness, access to health care, being non-judgmental
Nurse 4, Minimum Security	Following codes of conduct, the law, respect for individuals, confidentiality, best interests, fairness, equivalence of health care (to the community)
Doctor 1, Maximum Security	Primacy of patient care, confidentiality, advocacy
Doctor 2, Maximum Security	Fairness, not knowing the crime, access to health care
Doctor 3, Maximum Security	Respect for patients' autonomy, best interests, equivalence of health care
Nurse 1, Maximum Security	Confidentiality, privacy
Nurse 2, Maximum Security	Equity, equality, reliability
Nurse 3, Maximum Security	Time to do everything properly, good strict guidelines

Participants were asked to reflect on ethics, values and issues specific to the correctional context. Essentially, practitioners were concerned with the issues of fairness, specifically that inmates retained their right to health care despite being deprived of their *liberty*.

> **Doctor 1, Minimum Security**: When I was thinking about what was important [there] was one issue which struck me as the most important thing because in a way, you always have to remind yourself... people who come in here, they have lost their liberty but not their right to health care.

> **Nurse 1, Maximum Security**: They have the right to have the same time as anyone else to health care.

Practitioners also expressed concern over their ability to act in the best interests of their patients.

> **Doctor 2, Maximum Security**: The main ethical problems I find working is trying to get the best possible care for my patients.

The majority of the participants thought that working in the correctional setting raised context-specific ethical issues and particular practical problems. These included such

things as negotiating security arrangements, problems with confidentiality and privacy, issues of access to health care and equivalence of care, dealing with lock downs, and dealing with difficult patients. Indeed one doctor found the situation so different to other clinical settings, they asserted:

> **Doctor 2, Maximum Security**: I don't think that there is any way that anyone who hasn't worked within Corrections could understand all the issues that confront us.

Claims of exceptionalism are discussed in the literature on correctional nursing and medicine (discussed in Chapter 2). This raises several questions, including the obvious: Is providing health care to inmates in prisons really unique? If so, do normative ethical and professional standards and values still obtain? This issue will be further explored in Chapter 9.

There was one exception to the generally held view that working in prisons raised particular and distinctive ethical issues and challenges. One doctor commented in a very short interview:

> **Doctor 2, Minimum Security**: If you ask me specifically does it raise ethical issues and different from practising outside, I'd say no.

5.1.2 It's Not Ethics

While many of the participants could identify ethical values and issues, some of the participants had difficulty responding to questions about ethical values and articulating the ethical issues they face in day-to-day practice. In some cases, common values with ethical implications were not recognised as such.

> **KW**: And the other thing that has come up with my other interviews... is confidentiality and privacy.

> **Nurse 4, Minimum Security**: I wouldn't have put that down as ethical. But that probably is too, sure. We've got to definitely maintain privacy that poses dilemmas for us.

This may be because some of the values or issues of ethical significance are considered legal rather than ethical concerns in the prison context. Similarly, it may be that some clinicians subsume ethics and ethical issues, such as consent and treatment refusal under clinical concerns.

> **Nurse 3, Maximum Security**: We have the [specific unit at the maximum security correctional centre] and it's a quasi-psychiatric unit but it is not exactly a psychiatric unit because you can only treat patients with their consent and this is a problem because people who are faced with psychiatric illnesses sometimes don't take medication. And so this is one problem that we face, but that is a practical issue, it is not really an ethical one.

5.1.3 Confidentiality

Confidentiality is one of the moral rules identified by Beauchamp and Childress[1] and is closely identified with trust. This value was identified as a central ethical concept by health care practitioners working in the prison context. Moreover, maintaining confidentiality poses acute problems for them in the prison context. Of the 13 clinicians interviewed, 12 raised the issue of confidentiality a total of 44 times. This reflected not only the centrality of confidentiality to ethical practice articulated by participant clinicians, but the difficulties in maintaining confidentiality in prisons. This is particularly the case in maximum and medium security prisons where security policies which aim to protect health care practitioners from inmates would effectively proscribe confidentiality, eg. sight and sound requirements. The sight and sound policy requires all health care interactions to be within sight and sound of a

[1] Beauchamp, T. Childress, J. *Principles of biomedical ethics,* 5th edn, Oxford University Press, Oxford, 2001.

correctional officer. Given confidentiality is a legal, ethical and professional obligation this becomes highly problematic for practitioners. Even though clinicians practising in minimum security prisons are not required to adhere to a sight and sound policy, the practical arrangements of health care delivery in prisons - sick and methadone parades, custodial officers escorting inmates to (outside of the prison) hospital or specialist appointments and so on - makes maintaining confidentiality difficult.

Because of these factors, it is no surprise that health care practitioners cited confidentiality as a major ethical principle, which is not only critically important to their practice, but potentially compromised by the prison context. The following quote from the doctor cited below provides a typical answer to the question about central ethical values.

> **KW**: And what ethical values are important for your practice here?
> **Doctor 2, Minimum Security**: Confidentiality, patient care, review.

When asked why confidentiality was important in the prison context, several reasons emerged. Confidentiality was necessary for the practice of good medicine and for beneficent reasons. The health care practitioners interviewed deemed it critically important that prisoners knew that information given to their doctors and nurses would not be passed on to DCS. Thus clinicians reported that ensuring confidentiality meant that prisoners were more likely to disclose health related information. The following quotation is an example of the script used to reassure inmates about confidentiality.

> **Nurse 1, Minimum Security**: My opening gambit is I introduce myself and say look this interview or whatever you're here for is completely confidential, nothing goes outside this room, all documentation, all the files, are kept under lock and key, they go from me to the filing room, and that's that. So no one in

the Department of Corrective Services has access to the file, the only people that do are health workers. No one outside, no welfare workers, psychologists, or anyone like that, just people who are employed by Corrections Health.

Only under these conditions will health care workers gain opportunities to dispense advice about harm minimisation. And clearly, as the quote below shows this approach works in some cases.

Nurse 4, Minimum Security: you'd be surprised what they do tell you in confidence, particularly when you are filling out the methadone into the containers and they tell you that they are using in here, or that they have access to syringes and things, it just staggers me that they are so honest and open with you. They tell you things, I presume on the understanding that they know you are bound by this confidentiality, and um you just give them the advice to safety, you know, that they know what they are doing, that they aren't sharing.

Maintaining confidentiality was considered important for utilitarian reasons: good consequences ensue when confidentiality is guaranteed in that clinicians learned more health related information from their patients and the patients were more inclined to trust them. Moreover, clinicians learned more about risky behaviour, which created an opportunity for providing advice about minimising harm. The guarantee of confidentiality was also critical to credibility: and not just credibility for the current patients, but for future patients.

Doctor 3, Maximum Security: I am internally mindful of the fact that if an inmate thinks that I have revealed things about what they've told me in a malicious or reckless way, I won't be forgiven. And that will be announced to the whole of the gaol, and in places like that, those announcements then pass down to the generation of inmates, so it would destroy any credibility I have.

Corrections health care practitioners, like other practitioners, are required to write many reports and notes about their patients. Some of the notes and reports are available only to other employees of CHS: that is, similar to other, more familiar, health care settings. Some reports are for the information of other health care practitioners external to the correctional setting: for example when patients are sent to

outside health care facilities for tertiary care. Some reports written by the clinicians are for courts, and/or probation and parole purposes. Clinicians must tread a fine line with probation and parole reports. On the one hand, reports about a patient's mental status or behaviour are clearly relevant to those responsible for assessing whether a prisoner is ready for parole. On the other, the clinician must act in the best interests of his or her patient. This will usually mean keeping health information confidential. Apart from the conflict between maintaining confidentiality, or at least deciding what to report and what to leave out, while at the same time providing accurate and appropriate information to probation and parole, clinicians must avoid being viewed by patients as providing information which may stop them from being released from prison. The doctor reported below is faced with such a dilemma. Their solution was to gain the patient's consent to disclose to a third party.

> **Doctor 1, Maximum Security**: the Probation Parole Board often seeks reports that obviously would be based directly on my notes. There is provision in the Act if I provide a report to them that I can ask that it not be revealed to the patient on the basis that it might represent some risk of harm to someone else. I don't like doing that. What I routinely do with reports to Probation and Parole is actually show it or read it out to the inmate because ...the inmate's view of my role is whether [they] get paroled or not. If they don't get it, it will be due to something I've said. If they do get it, it will be because I have said the right thing.

In addition to stating the importance of confidentiality to their practice in the prison setting, clinicians also spoke about difficulties in keeping confidences in prison and reasons why they would override this presumptive, ethical obligation. There are two reasons clinicians cite for overriding confidentiality. Overriding confidentiality for ethically important reasons such as harm to others is not unusual in health care practice in any context. Clinicians will breach confidentiality when there is real potential for harm to a third party. There are differences in the prison context to other, more usual contexts, however, and these inevitably relate to security issues.

Policies relating to security such as reporting intoxication or self harm mean that most of the nurses interviewed will breach patient confidentiality by reporting the incident. Their reasons for following the policy are either that the policy is in the patient's best interests or because security concerns must override patient confidentiality. In the following example, it seems as if appealing to best interests is a way of justifying following a policy which overrides professional and ethical obligations to patients.

> **Nurse 3, Minimum Security**: at times you feel like "Oh they've confided in you" but you have to follow policy, it is in the best interest of the client anyway.

5.1.3.1 Reasons to Override Confidentiality

Some of the nurses interviewed were critical of their obligations to ensure patient confidentiality. Several nurses spoke of an instance which involved the case of a prisoner with a history of hostage taking and violence – both when she was in a public hospital and in gaol when she took her solicitor hostage during a routine visit. The patient needed to be sent to a tertiary hospital via ambulance because she was unwell. The ambulance arrived and a nurse and the correctional officers escorted the patient to the ambulance. The nurse expected that the prison staff would inform the paramedics of the woman's criminal history. When they did not the nurse informed the ambulance staff that the patient was known to take hostages. The nurse was subsequently disciplined for her actions. The nurses who spoke to me viewed the disciplinary action as unfair because the ambulance officers and hospital staff had a right to know the patient's criminal history. They reasoned the potential harm to the ambulance officers and hospital staff outweighed the harm done by breaching confidentiality. The inmates' perspective was that the nurse had improperly breached her ethical obligations and consequently they were angry. This is also an example of how brittle trust is in this context.

The doctors interviewed also spoke about what reasons justified overriding or breaching confidentiality. One doctor explained that they owed a duty of care for others as well as their patients. If patients vocalised their violent intentions to others, then the relevant authorities must be alerted. Prisoners will accept breaches of confidentiality under certain circumstances. One participant described how they had informed a correctional officer he was at risk from a delusional patient. The other prisoners heard about this and thought overriding confidentiality appropriate in this case because "she was mad!" Both doctors and nurses accepted that confidentiality was a *prima facie* ethical obligation.

> **Doctor 1, Maximum Security**: You made me think that there are certain standards that do override confidentiality, and occasionally I'm told by one inmate that another inmate has exhorted another inmate to cut themselves up, or to hang themselves, or try and kill themselves in some way. But it is obviously very destructive and if I think that in this case the information I've got is probably correct, and I think I have a duty of care in that situation to try and do something about it. And that does not necessarily mean just reporting to the custodial authorities what I've heard, you try to do it in a rather more sophisticated way.

Clinicians also related stories about how breaches of confidentiality could have negative consequences. The following example is of a doctor who was asked to write a report to the Parole Board about a patient with a severe personality disorder.[2] In this case the doctor did not discuss the content of the report with the patient because the doctor had grave fears about this particular patient's ability to function in the community and "the safety of the community with respect to the sort of things that she did... [as] she was a particularly vengeful sort of person." The doctor asked that the report be made confidential because if the patient was aware of what was written

[2] This case differs markedly from one cited previously in which the doctor routinely asked for the inmate's consent before reporting to probation and parole.

in the report, it was likely she would seek retribution. However, the patient was provided with information about the report, including the reasons why the report ought to be withheld from the patient. This situation is further complicated by the fact that the patient has been sent back to prison, still requiring medical care from the person she believes is responsible for writing a damning report about her.

> **Doctor 3, Maximum Security**: This woman is back in gaol because she has breached her parole and she has asked me to see her again because she needs to be medicated and she needs someone to listen to her, so its compromised my continuing care of this woman because there is that issue that hangs over us now and I have to try and be in a therapeutic [relationship] with her as I think I need to be, she has a serious disorder and yet I feel this is always there lurking in the background.

While the above situation is unusual, it is not an isolated incident. These cases also represent a source of conflict between health care and custodial staff.

> **Doctor 1, Maximum Security**: Yeah, I've got one patient who knows my home address. It was inadvertently given to the patient by no less than the Parole Board. Inadvertently, but they should have been aware that that would have put me at risk. And this is a stalker.

Practitioners, then, articulated some of the difficulties in maintaining confidentiality and privacy. The difficulties stem from several sources: the usual ones in which health care practitioners must override patient confidentiality to prevent greater harm and for security reasons including writing reports for groups not related to health care and security policies including sight and sound and reporting intoxication. Confidentiality and privacy are also issues because of the arrangements for dispensing medications and making appointments.

5.1.3.2 Unintended Breaches of Confidentiality

The Methadone parade takes place every morning. Women prisoners requiring their methadone must front up to the pill window and be given their dose. Similarly, other routine and non-routine medications are given out at the 'pill window'. Inmates can use this opportunity to request a medical or nursing appointment. I made the following statement in response to observing the morning sick parade. It was a stark example of how context militates against what is normally considered ethical practice.

> **KW**: While I was waiting for this interview I was watching the nurses give out the pills to the patients at the window. The patients are screaming out what pills they want and the nurses were screaming back. It is hardly confidential.

Patients who need tertiary or specialist health care are transported to a public hospital for medical treatment. Inmates are accompanied by custodial officers, who must stay with the patient at all times.

> **Nurse 3, Minimum Security**: There is a confidentiality issue with the officers because they're desperate to know what's wrong with these girls and it is a problem in that when the girls go to hospital the officer is by the bedside, so they know more than what the nurses do, they know what's wrong with the clients.

Enforcement of the sight and sound policy would mean that confidential discussions between health care practitioners and patients would be impossible. There is a clear need for such a policy in some circumstances: just before doing these interviews a nurse had been stabbed in the clinic. None of the practitioners I interviewed at the maximum security facility followed the policy to the letter, and only one participant, an inexperienced nurse from the minimum security facility, stated health care staff ought to always have a correctional officer with them during interactions with prisoners. The reason given by the nurse was that they felt unsafe working with inmates.

5.1.3.3 Protecting Patient Confidentiality

The medical and nursing explained that it was important to protect patient confidentiality and privacy, and they do this in various ways.

> **Doctor 2, Maximum Security**: We shut doors
> **KW**: you can shut doors?
> **Doctor 2, Maximum Security**: yeah, yeah, um when I first went to [the maximum security prison] the usual practice, what I observed with Dr Q was that the door was left open and all the conversations were heard. I had a lot of trouble with that, and not initially but after a while I shut the door.

The policy was modified by the clinician to 'sight only' as the correctional officer outside the door could view the interaction by looking in through a small glass window. This however is problematic for some clinicians, particularly those caring for obstetric patients or providing women's health care. One nurse interviewed refused to be in either sight or sound of a custodial officer.

> **Nurse 1, Maximum Security**: There have been some officers who have come in and said you have to take that off; I've got an envelope over the window in my door. I say, "Fine, I won't have a clinic". I am not going to work unless I know that I can say to the women your privacy is safe in here.

Many of the participants report cases where a concerned custodial officer will indicate to the clinician that they are worried that a particular patient is violent and, consequently, may harm the health care practitioner. Practitioners manage this situation in various ways. Some practitioners see patients in the presence of an officer, but avoid asking leading and potentially damaging questions.

> **Nurse 2, Maximum Security**: So I was very careful and on those rare occasions I've actually left the door open or, on two occasions I've had an officer in with me, but I'm very aware and ask questions that aren't as incriminating as they would be under normal circumstances, but I value my life. And these people, the two people I've been speaking about, have been committed, tried and sentenced for murder, and also have been known to take workers hostage. So I certainly wasn't going to let that happen to me.

Other practitioners negotiate with their patient.

> **Doctor 1, Maximum Security**: They bring someone up and say Doc this woman is just too dangerous for you to interview, is it all right for me to stand at the door with the door open, and I wouldn't do that. So I ask the person to come in and say this is what they've asked me to do, I'm not prepared to do that, will you give me an undertaking that we can sit down here together and I close the door and tell the officer outside that you'll behave yourself. In my experience they invariably do behave themselves.

The following case shows how clinicians, in this case a nurse, grapple with issues of confidentiality in the prison context.

> **Nurse, Minimum Security**: I had this young girl, about 20 years old, and she came here one morning saying she had been sexually assaulted by one of the inmates. She gave me the inmate's name, one of the older inmates that I knew quite well as well, and the dilemma was that she didn't want anyone to know, number 1, number 2 was she was quite distraught, she was a vulnerable young girl to start with, a Koori girl on top of it. The other girl who assaulted her was a Koori girl as well. Anyway, she didn't want me to tell the officers of course. But I have a duty of care to report any suspected assaults to the officers. So frankly I had to look up the Policy Manual to see, and the manual said you *had to report it* and get her sexual assault counselling. I didn't report it as a sexual assault to the officers - my dilemma was that by reporting it I was frightened that other girls wouldn't approach us and tell us, ... the other girls will hear about it, and they won't tell us either, and this girl's a sexual predator, she already had this reputation at [maximum security correctional centre], and so I didn't report it as a sexual assault.
>
> But I reported it to the officer as an assault and I said to her that they will interview you and it's up to you what you say. She went to the hospital that day to see the counsellor. I just didn't know what to do. As for the person, that's the other thing, I'm still stuck on that, I still didn't know if I did the right thing. I didn't report who the actual person that caused the assault. She's horrible. And also this young girl, she was due out in a couple of months, she lived around the corner from this girl as well, and that was another dilemma. Because she'd be out in the community with her, and this girl who is quite a prominent figure in the Koori population, would get others to do her dirty work basically so the girl's scared, but at the same time, she needed help, she needed support. It was horrible, I didn't sleep for nights, and I didn't know what to do (emphasis added).

The story recounts an occasion in which a nurse was told of a sexual assault and was required by policy to report this to the prison authorities, even though the victim wanted to keep it a secret. The policy required the nurse to breach patient

confidentiality. The nurse reported the sexual assault as an assault and while patient confidentiality was still breached, it was done in a way the nurse hoped would protect the victim to some extent. Furthermore, by not reporting the sexual assault, the nurse hoped other patients in the same or similar situations would seek treatment and advice from the nurses. The second dilemma for the nurse was that by not reporting the perpetrator of the sexual assault to the prison authorities the nurse does not expose the victim to reprisals when she is released back into the community. But by not reporting the sexual assault and naming the perpetrator to the custodial authorities, the nurse ensures the continued exposure of the other inmates to on going predatory behaviour.

5.1.4 Autonomy, Respect and Consent

As discussed in Chapter 2, the principle of autonomy and respect for persons are important ethical concepts and feature in health care ethics and bioethics texts and the CHS code of ethics. The clinicians interviewed for this research raised autonomy and respect as central ethical concerns (see Table 2).

The quotation, cited below, indicates that the principle "respect for persons" was also expressed as a means to an end. Demonstrating respect for patients not only encouraged them to treat health care staff respectfully, respecting patients created a space in which patients could respond in good ways to health care practitioners and their treatment.

> **Doctor 1, Minimum Security**: I think a lot of the women have been so used to being treated badly, that if they are treated with an ounce of respect, they actually are quite easy to get on with - the majority. There are those who are threatening, no matter what you do, and certainly we have had some very threatening patients who threaten you with this, that and the other thing.

Respect for patients was construed in quite complex ways by some participants. Rather than merely respecting a person or respecting a person's autonomy, respect involved genuine liking, authenticity, compassion, and honesty. Respecting patients meant taking them and their problems seriously and genuinely responding to them.

> **Doctor 3, Maximum Security**: In my practice here, number one is respect for the patients. For me that it is the most important thing, to respect your patients and to try and do the best you can for them. I find that when I show respect for them I get respect back in return. I am very straightforward, I am very approachable, very interested in what they are saying, I listen to them, I give them good advice if they need it, I talk through their problems, anything they think is trivial I take everything very seriously, what they say. There is not one person that I don't like, which might be strange, but no I like them all, I do... Again where anti-depressant medications are concerned I explain to them in detail about anti-depressants and the role of anti-depressants and we try them and if they don't like them well we discuss them, go off this one and try something else because again, I stress to them that I am there to help them, that's what my role is. We discuss things very openly; the main thing is that I generally do like them.

5.1.4.1 Consent

Consent was a particular issue for the medical practitioners interviewed for this study. Doctors were more likely to raise consent as an issue, both in terms of the need to seek consent for the care and treatment for patients and the problems associated with gaining consent from patients. Consent was an issue for some practitioners in the usual ways: the requirement to ascertain patients' informed choices for their care and treatment, and in ways not usually confronted in health care practice. The following extract describes a doctor informing a patient about a court report.

> **Doctor 1, Maximum Security**: Now taking the view that rightly or wrongly... I will write the report to the court where the person consents for me to do so, I say look here I've been asked to do this report, I'm happy to provide a report for the court but I will need to know whether you consent to this. Well of course their first response to that is "Well what are you going to say Doc? Are you going to say the right thing?" ... I have seen patients who I say to at the end of that interview that I am not sure whether there is anything I can say that would

be in their interests,, I can write a report but I really don't think that anything I've got to say is going to help you, and mostly they say "Well you'd better not write anything Doc." I write back to the court and say I do not have the patient's consent, full stop. I don't give reasons why, I just say that.

While consent was mainly an issue for the medical staff, the nurse responsible for women's health issues was also concerned with consent. The nurse recalled a situation in which correctional officers suggested that the nurse perform a vaginal examination on a patient. There was no valid medical reason why the patient should be examined vaginally (eg, a pap smear) When the nurse queried the suggestion, the officers said that they had suspicions about whether the woman had secreted drugs vaginally. The nurse refused to do a vaginal examination without the consent of the patient.

Participants also raised the problem of caring for a population in which a large proportion was unable to consent to their care and treatment. A high percentage of women incarcerated suffer from severe mental illness. These women, by virtue of their medical condition, were unable to make meaningful health care choices.

Doctor 3, Maximum Security: I deal particularly with some of the most impaired members of the community, people that are multiply disadvantaged and whose mental state is of such a nature that they are not in a position to make informed consent or to even do sensible judgments about important issues that concern their lives.

5.1.5 Justice

Issues of justice, Beauchamp and Childress[3] maintain, are of profound social importance. This concept also features prominently in discussions about prisons and the obligations of health care practitioners working in the prison context. The

[3] Beauchamp, T. Childress, J. *op cit.*

importance of justice, construed as access and equivalence, is reflected in a key aim of CHS.

> To improve the health of people in the New South Wales correctional system to an optimal level and to maintain the status by provision of care that is the same standard and quality as that available to the wider community.[4]

The majority of the health care practitioners raised justice as an essential ethical value in the prison context. Justice was understood by clinicians in several ways, including in terms of allocation of resources. Clinicians spoke about the lack of health care resources available to them and not having enough time to care for their patients. This is not unique to the prison context; the same problems are experienced in many hospitals.

> **Nurse 1, Maximum security**: It's too many [patients] to see to start with, so the resources are too thin on the ground. I haven't got enough hours in the day.

Most of the discussion about justice centred on two constructions: the first was justice as access to health care and the second was community equivalence. Justice issues were evident in clinicians' talk about prisoners' rights and to be treated with respect. The main issue clinicians spoke about pertaining to justice, both in terms of access and equivalence, was the lack of a needle exchange programme in NSW prisons. For many, this was the single clearest example of incarcerated inmates not receiving the same health care as they would outside prison. All the staff who raised this issue understood why custodial authorities were opposed to health care practitioners supplying clean needles and syringes; nevertheless, most still argued they ought to be provided.

> **Nurse 2, Maximum Security**: Herein lies the other ethical issue, particularly pertaining to my work, the fact that we don't offer a needle exchange program in this gaol. Now this would be as controversial as you could possibly get, but it is

[4] Corrections Health Service *Strategic Directions Statement and Plan 1999-2002,* p.5.

certainly an ethical issue because the philosophy of the present State Government is to offer equal service to those people incarcerated as they would get on the outside. Now on the outside, any intravenous drug user has access to new needles and syringes - they certainly do not in gaol, 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-born disease. It's a huge ethical issue.

In the following extract the nurse interviewed clearly outlines some of the dilemmas posed by providing needle and syringe exchange programmes in prison. Yet despite all the difficulties and problems this would raise, not the least being having to convince the custodial authorities, the nurse still argues that clean needles and syringes ought to be available for medical reasons, given the number of women in prison with hepatitis. While there will be practical problems with distribution, there are already needles and syringes in gaols. Underpinning the nurse's argument is the philosophy of harm minimisation and harm minimisation is an issue of community equivalence.

Nurse 2, Minimum Security: From a medical stand point it would be vital to have clean syringes going out there without incidence of Hep C ... and the dangers of catching other strains of it. I mean 80% of people here have Hep C but the danger here is using and sharing needles and getting another strain. We have young girls here with quite aggressive hepatitises. So from a medical viewpoint I strongly believe that there should be some provision of clean needles because they always will use, and it is never going to stop... There is stuff coming in every weekend and every day

The whole dynamics of the relationship between officers and inmates would have to change in for the officers to accept [clean needles] coming in. It is gradually changing, but because of that fellow stabbing that officer and him being HIV, he got it very rapidly, he sero-converted rapidly and died within a short time. I used to teach at the academy and they have a very, very narrow viewpoint, a lot of the officers. It would take so much for a cultural change and attitudinal change and then the violence issue. Because they still believe [needles] will be used as a weapon.

I'll say to the officers that there are probably about 10 syringes in circulation at the moment here: two hundred girls, 10 syringes. You have already got ten syringes in here; you know whether it is 1 or 10 or 50 syringes they are already here. Wouldn't you prefer them to at least be clean? ...

> And I also don't know how, then we would have the dilemmas, confidentiality and how can people pick them up, but all that sort of thing... They were talking about putting them on buy-ups, so you could imagine them saying "I'll have them two syringes, two packets of arrowroot biscuits".

5.1.6 Advocacy/Best interests

Advocacy is a concept most commonly used in relation to law, and means to plead a cause, or to provide support in a court of justice.[5] The idea that patients are similarly situated in that they also need an advocate, a professional to support or protect them, has been taken up by health care professionals, particularly nurses who have stressed the concept's ethical significance. It is less common in the medical literature, though psychiatrists are more likely than other medical practitioners to discuss their obligations to patients in terms of advocacy.

In the interviews, only 5 (3 doctors, 2 nurses) of the 13 participants spoke about their advocacy role for patients in the prison context, and the concept was discussed 10 times. It is clear in the participants' narratives that advocacy is synonymous with beneficence or best interests. Thus, when practitioners spoke about being their patients' advocate what they usually meant was they were acting in their patients' best interests. As an aside, given the importance of advocacy in the nursing literature and the emphasis placed on it in nursing curricula, I would have anticipated that this concept would do more ethical work in the context of prison nursing.[6]

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[5] Little, W. Fouler, H. Coulson, J. & revised and edited by Onions, C. *The Shorter Oxford Dictionary on Historical Principles,* The Clarendon Press, Oxford, 1964. p.29.

[6] Thacker, KS. Nurse's advocacy behaviours in end-of-life nursing care, *Nursing Ethics,* 15:2, 2008. Nettina, SM. Nurses: the perfect patient advocate, *Topics in Advanced Practice Nursing,* 5:2, 2005.

Nurses discussed advocacy and their role in advocating for patients, but in unanticipated ways. One nurse who explicitly mentioned advocacy and the nurse's role as patients' advocate did so in terms of advocacy being a problem in the prison context and in terms of "agendas". The nurse's agenda – advocacy – was to provide appropriate treatment to and for patients. The patient's agenda was to scam the nurse, to use her or him to achieve their own objectives, specifically acquiring drugs.

> **Nurse 1, Minimum Security**: Trying to advocate for patients as a nurse and doing that wholeheartedly is difficult when you know that they are basically not interested in what you're doing, they have their own agenda and want something else. It is so difficult to do your best. For example: when they want sleepers [sleeping tablets] and you need to talk to them about why they are depressed and screen them, but ... they are just lying ...and their agenda is they want sleepers not treatment and it is very hard to cope with that and still retain management and implement a care plan. Those sort of things you know, when you think bugger this, what's the use, they are just scamming me. And it is a bit annoying, annoying.

The doctors interviewed in both the maximum and minimum security prisons were more likely to discuss advocacy in terms of particular patients and in specific ways. Moreover, the doctors were more cognisant of their advocacy role in the *prison* context. Not only did doctors speak of the need to advocate for their patients in general terms, they must advocate on behalf of the patients because they were in prison.

> **Doctor 1, Maximum Security**: I feel it is important to take on an advocacy role. It is absolutely critical here [in prison].

One medical interviewee was keen to locate the importance of advocacy, both in terms of how the wider community views prisoners and how the medical/health care community treats prisoners, as political issues. The doctor was concerned with how prisoners were treated in general hospitals, specifically accident and emergency

departments, as staff working there were inclined to view such patients as unimportant.

> **Doctor 1, Minimum Security**: I think a lot more could be done in terms of advocacy in accident and emergency units and at all levels and specifically for the client we have here which is largely drug and alcohol dependent people or for people with poor backgrounds. I remember as a junior resident at a hospital they were always kept across in the corner and don't worry about them until you see the real cases.

This doctor drew parallels with the insensitive treatment of prisoners in hospitals to the general population's attitude to prisoners. The current NSW government and opposition have run the political line of "getting tough on crime". These policies have not only led to an increase in the numbers of women in prison, they underscore community indifference, if not hostility, towards [women] prisoners. These women, the doctor argues, are disadvantaged because they do not have strong advocates and discrimination and disadvantage require advocacy.

> **Doctor 3, Minimum Security**: our women in some ways are similar in that they don't have a strong advocacy voice and people don't want to listen about them they just want to hear about them being locked up.

5.1.7 Trust

Trust is essential to any health care relationship; patients would not visit a health care professional unless they trusted that they were acting in their best interests. And according to the interviews, this seems particularly true in the prison context. Inmate patients must trust that their medical records are confidential to CHS staff, that they can confide health related illicit behaviour, and so on. It could be anticipated, however, that women prisoners have every reason not to trust the system and, given their background, not to trust those in authority.

The majority of the health care practitioners interviewed spoke about trust: either in terms of how surprisingly easy it was to gain the trust of their patients, or how difficult it was to gain their patients' trust. Some discussed trust in terms of how 'fragile' trust was between health carers and their patients. Indeed, there was no consensus on trust; some health care practitioners found particular groups of prisoners less trusting of them, some found the same prisoner groups more trusting.

This particular issue was raised in relation to Koori patients. One nurse, in response to the question whether of trust was hard to establish answered:

> **Nurse 4, Minimum Security**: I think that's more so in the Koori girls, they feel very isolated, some of the ethnic girls do too, actually.

In response to the same question the doctor employed to care for Koori patients had no difficulty establishing trusting relationships with Koori patients.

> **Doctor 3, Minimum Security**: No not really, they trust me because the Aboriginal Medical Service employs me.

Some clinicians were surprised by how trusting their patients were in the circumstances. The doctor in the following extract is surprised by the patient's openness and how this can be achieved readily and without the need to really understand them. Trust though, needed to be tempered with the knowledge that many of these patients were inclined to manipulate and lie.

> **Doctor 2, Minimum Security**: They seem to trust me, incredible from my side. I put it down to the ability to develop a rapport with them, without any specific thing, to get on their wavelength and understand them, and have some empathetic relation and sometimes they tend to tell you a lot... A large amount of prisoners have an ability to fabricate and then change but most of that you get out of what are their distresses and the story line and work out the truth from that.

One nurse connected trust to truth-telling. Patients trusted health care professionals who told the truth and were reliable:

> **Nurse 3, Maximum Security**: I've never told a lie ever. You never think that you're friendly with them because you're on the other side, there's always a professional relationship, and they know that if I did some things, like can you put me down for the dentist nurse, they know I will put them down for the dentist.

When asked why they thought trust was so easily established between heath care providers and their patients, one nurse suggested an instrumental reason. It was not trust *per se*, but rather the need to have their problems solved and to get help.

> **Nurse 3, Minimum Security**: I don't know so much as trust, I think that comes into it but they tell us because we help them with their problems and if they don't tell us their story how can we fully help them?

Some practitioners spoke about the difficulty of establishing trust with their patients. One nurse talked of how trust must be built up and, if and when a trusting relationship was established, it could be easily destroyed. According to one nurse, trust is dependent on giving the patient what they want. In the usual health care context, trust between health care practitioners and patients is more robust.

> **Nurse 1, Minimum Security**: And you can do a lot to build [trust] up... You can build it up but it doesn't take a lot to damage it either, a whole of groundwork can be damaged so easily by not giving them what they want.

Trust is relational and bilateral. Patients trust their health care practitioners, and health care practitioners trust their patients. In the prison context it is harder for trust to occur in the usual and straightforward ways. Many inmates, for what ever reason, are highly manipulative and health care practitioners would be foolish to naïvely trust their patients. The latter point is articulated by one of the doctors.

> **Doctor 1, Minimum Security**: Another thing I want to talk about which personally I find difficult is how to manage when people are lying to achieve whatever it is they are trying to achieve, whether it be claiming medication, whether it be special privileges of some nature. I find it very hard trying to

work that one out, because you can't think everyone's lying, but you can't be naïve. We get more than our fair share of liars here and sometimes to be fair to the girls that is the way they survived, the way they've survived on the streets...

5.1.8 Veracity

Veracity was less of an issue in this context than I would have anticipated. That is, clinicians spoke about manipulative and lying patients, but the usual discussion of veracity in terms of telling the truth to patients did not appear to be an issue in the prison context. There were some instances in which the truth was withheld from patients. Patients were not informed about the details of their outside medical appointments, such as the date and time they were required to attend. This information was withheld from patients for security reasons.

5.2 Professional Values and Standards

Professional values and standards are those which the clinicians interviewed raised as central to their practice, or as problematic in the prison context. These included their ability to maintain standards, their duty of care, maintaining professional boundaries and the need for teamwork.

5.2.1 Maintaining Standards

The issue of maintaining standards in the prison context was a relevant and concerning one for clinicians. They discussed maintaining standards in several ways: difficulties they face; strategies they use; and personal standards.

The *difficulties* in maintaining standards of care were articulated by participants. Some practitioners compared their practice in the correctional setting to the care their patients would receive outside prison. The nurse quoted below is concerned by her inability to access medical staff to check on a patient. This is a very different situation to that found in hospitals close to the two correctional centres where doctors can be called to see patients in a more or less timely way, or even in general practice. The situation described by the nurse below mirrors the problems of access found in many rural areas of Australia. But the two correctional centres visited during this research are close to several teaching hospitals. The nurse is also frustrated by the length of time it takes for patients to see doctors within the correctional system.

> **Nurse 2, Minimum Security**: Sometimes it is frustrating that you see a client and you would feel happier to have medical input and you know you are not sure [and] you would like to run it by a medical officer which you could do in, in the hospital system certainly, whereas here maybe you would have to, and you can't get them in to see a doctor up to 2 weeks, that is very frustrating, certainly.

Maintaining standards is compromised by lack of time. This situation is not unique to providing health care in the prison setting. Health care professionals in general are frustrated by the number of patients they must care for, and how the care they do provide is compromised because they do not have enough time to spend with each patient. Medical and nursing staff interviewed for this project complained about this problem.

> **Doctor 3, Minimum Security**: As a doctor [here] you don't have an enormous amount of time to spend with the patients, and so actually you cannot really get into the psychological side of things very effectively.

Another feature common to the public hospital system is the lack of resources vital to the provision of basic nursing care. The nurse quoted below makes the 'all too familiar' nursing refrain about lack of linen for patients; however, the situation is

extreme in the correctional context. The nurse does not even have enough mattresses for her patients to lie on.

> **Nurse 3, Maximum Security**: No. We have no sheets, we have no towels, we have no mattresses, and I have no nighties to put girls into. If I bring a girl into the annexe hospital section from the wards, from the units, who is sick ..., you have to bring the bedding from the unit. Now they want a shower, we have no towels, and this is going on and on.

Some clinicians spoke of the difficulties of maintaining heath care standards because of the tense relationship with DCS. This will be discussed more fully in the following chapters, but essentially some practitioners complained about both the custodial officers and the prison administration interfering in the management of patients. Common complaints included that some officers 'wound the patients up' making treating them difficult, having to cope with 'lock downs' so prisoners cannot attend medical or nursing appointments, unprofessional attitudes and behaviour of custodial staff to patients, inappropriate requests from prison administration and most importantly how security practices – especially safe cell practice - are antithetical to good health care. The criticisms about DCS personnel must be balanced, however, with comments about professional and helpful DCS staff.

> **Nurse 1, Maximum security**: Some of the officers are great - both men and women. Today there were two excellent men working in the clinic. The third one, as the expression goes, wouldn't work in an iron lung. And he was driving them mad as well as us. But there are days, a lot of days where I would come into work and I'd get to the top step and think "Oh no" and I'd almost want to go home because I knew the attitude of the one that was running the clinic. He would stir up all the women, he'd say something and then they would back answer him, then they'd be in trouble then the next thing he would throw them out because they [the prisoners] can't speak like that to the officers. So I'd wonder where the women were because he'd got rid of them. So fortunately at the present moment we don't have him working in the clinic. But there are other officers, men and women that I wouldn't want to ever to have anything to do with, let alone work with. It makes a huge difference to how the whole clinic works.

Clinicians used various strategies to try to *maintain standards* given the difficulty and complexity of the prison context. Some of the nurses spoke about the importance of respecting their patients, about ensuring confidentiality and privacy as a way of maintaining standards. Because the prison context and security concerns made providing equivalent care to that of the community problematic, maintaining one's personal ethical standards took on greater significance. The nurse in the following example demonstrates the strategy they used, not only maintain personal standards, but to resist acculturation to prison norms.

> **Nurse 1, Maximum Security**: I always hold up a sheet when they are getting out of their clothes. And often they really acknowledge that. Often they say, "Oh you get used to this in goal or it doesn't matter in goal" and I say that's how I feel comfortable working.

Professional standards also play a protective role for both the patient and the health care practitioner. One doctor relates how hearing so many patients' difficult life stories led to their disengagement. It was as if this doctor had compassion overload or burn out. The doctor sought to overcome this problem by appealing to, and maintaining, their professional standards.

> **Doctor 3, Minimum Security**: Another thing is that you have very careful that you do not get too hardened because it is amazing how the stories are all so dreadful, but they are all very similar. I found after I had been working here a few years just being shocked with how I was having to pretend to be interested in these very heart rending stories. But I think that it is just natural and that's where your professionalism comes in that you deal with appropriately.

The prisoners' ability to control their environment is severely curtailed in prisons. One way control can be achieved is a getting a medical certificate. The following extract is an example of the types of requests made to the medical staff. The doctor who is quoted below maintains standards to avoid being manipulated by patients, both in terms of drug seeking behaviour and allowing patients to manipulate the system.

Of course, inmates are not the only patients who try and manipulate doctors for their own advantage, but in the prison context this is virtually the *only* way inmates can alter their environment.

> **Doctor 2, Minimum Security**: The group I deal with, female prisoners, are always very troubled and manipulative, I just deal with it and they are worse than some of the others outside but they are just people of extremes in that way. Drug seeking behaviour is very common. There is a fair bit of attempting to change their physical environment, in some way maybe by getting moved to somewhere or change jobs they don't like. I don't do it, it just doesn't happen.

The practitioners employed to care for the mentally ill in prisons face specific difficulties in maintaining standards. This will be discussed at length in the next chapters, but treating profoundly mentally ill patients in prison caused deep personal distress for the clinicians, precisely because they felt they could not provide an appropriate standard of care.

> **Doctor 3, Maximum Security**: It's very difficult. I find it very difficult to deal with because a lot of the patients that I do treat do have a mental illness and they should not be in prison, they should be in a hospital facility.

5.2.2 Duty of Care

Duty of care is both an ethical and legal obligation, and according to Beauchamp and Childress,[7] a manifestation of the principle of nonmaleficence. Other authors argue it is a manifestation of beneficence.[8] Tomlinson argues the duty of care is a contractual arrangement. "Society bestows special privileges (of licence monopoly, social status, income, tax support for professional training and so on) on health professionals, physicians especially. In return, society rightfully expects that those of its members who are ill will receive the care they need".[9] The majority of the participants raised

[7] Beauchamp, T. Childress, J. *op cit.*
[8] Berglund, C. *Ethics for health care,* 2nd edn, Oxford University Press, South Melbourne, 2004, p.69.
[9] Tomlinson, T. Caring for risky patients: duty or virtue? *Journal of Medical Ethics,* 34, 2008, p.358.

duty of care issues in the interviews. One way participants spoke about duty of care issues was to link non-maleficence with justice concerns. The respondents spoke about the difficulty of having to care for too many patients and, consequently feeling they had not adequately looked after them. The medical staff spoke about the problem of accessing appropriate tertiary and specialist medical care in public hospitals.

> **Doctor 3, Minimum security**: The public hospital system is so overloaded anyway and then you have the trouble with the escort service being overloaded and then you find these two systems meet each other and there are lots of areas for it to fall down. And it is very frustrating and even if the hospital is willing, you find appointments have been mucked up.

Reporting was also raised as a duty of care issue. Nursing staff, since they see the patients more frequently than the medical staff, were more likely to have to deal with the problem of intoxicated patients (this refers to illicit drug and alcohol use). In prison, reporting inmates suspected of illicit drug use is mandatory. The participants not only appealed to their ethical obligation to act in the best interests of patients to report drug use, they also appealed to their duty of care. In the following extract the nurse explains how illicit drug taking in prison must be reported for security reasons because intoxicated inmates are dangerous, both to themselves, and more importantly, to other inmates. Reporting was justified by appeal to safety and duty of care. The nurse quoted below maintains that reporting specific intoxicated inmates via a health problem notification form is a harmless practice. This practice does, however, conflict with professional confidentiality obligations. Therefore, some correctional policies are in direct conflict with some of the norms of clinical practice.

> **Nurse, Minimum Security**: I would give [DCS] the information that there are a number of girls who appear to be using amphetamines on a regular basis of a weekend. Because that a safety issue and a duty of care issue. When we get Rivotril in the gaol it is really dangerous... it's extremely sedative, extremely dis-inhibitive, and there are a lot of assaults as the outcome about 24 hours later.

So I would write an immediate memo saying it appears there is Rivotril coming into this gaol and [DCS} have their intelligence and we collate information so yeah I have no ethical problem telling [DCS] about that. It is not specific about a person. We have the health problem notification form to notify [DCS} about an *individual* who is intoxicated and so needs to be checked on a few times in the night. But that's *harmless* information (emphasis added).

The above excerpt demonstrates how security concerns can be justified by appeals to a duty of care. In effect this means professional values are subordinated to custodial concerns. It also shows how the duty of care concept can be extended to others: other inmates and the good of the gaol. A more important point is that while the nurse clearly states they maintain patient confidentiality, confidentiality is nevertheless breached.

In the following example, a doctor includes specific others who are at risk, in their understanding of a duty of care. This doctor maintains that if a patient threatens another, and this threat is real, then a duty of care to the threatened person exists. This example can be contrasted with the treatment of the nurse was disciplined because she told the ambulance officer he was at risk (section 5.1.3.1 of this chapter). Medical staff, it appears, are treated differently.

Doctor 1, Maximum Security: we had a case where an inmate who had a particular delusional fixation on an officer who they thought was acting as an impostor, that the officer wasn't who they said they were, but another person who they believed was trying to kill them. I had a duty to warn that officer, which I did.

5.2.3 Impartiality

The issue of impartiality was only raised by the nurses at the minimum security correctional facility. As much of the CHS code of ethics related to boundary issues, it was not surprising that nurses were aware of the need to be impartial. While CHS

code of ethics applied to all health care staff, it referred specifically to nurses. Two of the nurses suggested impartiality was important because of their perception that getting too close to the patients was a trap. One nurse maintained closeness was problematic for the patients.

> **Nurse 3, Minimum Security**: But I try not to get too close [because] I think is dangerous for the client.

Another nurse reported closeness was a trap for the nurse.

> **Nurse 4, Minimum Security**: Try not to make any of them too special; some can break your heart. But they are all the same. You feel that you want to do [more for] the young girls, to show them extra kindness.

One nurse maintained impartiality was important because, otherwise, patients would manipulate them and potentially compromise the nursing and medical staff. Thus impartiality is important because favouritism will lead to problems between health care staff and patients.

> **Nurse 2, Minimum Security**: If there is an inmate that only requests to see one nurse, we will say "no you have to see the other nurses" because you can't develop just a relationship with one of the nurses because if they're off sick what are they going to do if they've got a problem. You just can't have like a favourite nurse or a favourite doctor. I don't know if inmates try to split staff but they say things about other staff members, the nurses they don't like.

5.2.4 Being Non-Judgmental

Being non-judgmental was mentioned by 2 doctors and 2 of the nurses as an important ethical value in the prison context. Being non-judgmental related to their patient's criminal history and not allowing that to impact on or influence the care provided to patients. Being non-judgmental is a common professional virtue and common in the nursing literature; in the prison context this virtue becomes accentuated.

Doctor 2, Maximum security: I think what I try to do is to look at fairness, try to look at someone without looking at their history, ... if they have committed crimes [because] whatever the reason they are inside, it really isn't relevant to the decisions I am making about their care

Nurse 2, Minimum security: Treating the girls all the same, I think it is good when the nurses are consistent, so consistency between the girls and the way you treat them and [being] non – judgmental. You can't let your judgement from outside come in so it's always good to have an open mind and just be there for the girls.

5.2.5 Teamwork

The importance of teamwork is a professional issue for nurses working in the prison context. This is mainly the case because of the isolation of clinical practice in correctional centres. Colleagues outside the prison system do not really or readily understand the pressures and stresses created by the prison context. Moreover, these clinicians have to deal with particularly difficult patients on a daily, if not hourly basis. The nurses spoke of having to rely on other nurses for support when faced with abusive and violent patients. The nurses interviewed related how important it was to work as a team when dealing with difficult patients.

Nurse 1, Minimum Security: Yes, they try to play one nurse against the other, but we are a very coherent team. So, we do a lot of hand-overs and stuff like that, this client has been doing this today so we all know it, so that client can't go to the next nurse with the same story and try to get medication out of that nurse, it won't work - so it's keeping the team together, it's what it's about, to try and overcome that problem.

Nurses usually work as part of a team, either in hospitals, as practice nurses with general practitioners, or in community centres. Several nurses, who have independent nursing roles or whose work spans both prisons, spoke about the problems of feeling isolated because they were not working as part of a team. This was further exacerbated by the fact that these nurses objected to the unprofessional way in which

other nursing staff spoke about the prisoners. They were doubly isolated: by working alone and by not sharing the values of the rest of the team.

One doctor raised teamwork as an issue, but that was largely in the context of patient care provided by DCS staff and the lack of communication between the two services.

> **Doctor 2, Minimum Security**: This is a funny system and as much as you would like to work together ... but they are not part of [CHS] staff and they have separate notes. In reality there is little communication between us. I'll say to the girls you need to see the drug and alcohol, you need to see the psychologist, and the psychologist says you need to see the doctor. I often ask the girls what the psychologist is doing, but I rarely see the psychologist myself.

5.2.6 Professional Autonomy Constrained by Context

Some of the doctors and nurses interviewed gave examples of how their clinical judgment and their professional autonomy were constrained by working in the prison context. Inexperienced doctors and nurses were inclined to defer to more senior colleagues on questions or issues involving judgment and professional autonomy. Senior staff, however, were more likely to raise this as a problem. There were two outstanding issues which are illustrative of how clinical judgment and autonomy is restricted or undermined by working in prisons. These are safe cell practice and non-medical persons questioning medical judgment. I have included quite lengthy quotes in this section because I think it best that, on central and critical issues, the clinicians should tell their own stories.

The first example is the use of safe cells. Safe cells are used for women who self harm. These patients are very difficult to treat and optimal treatment is labour intensive. The doctor interviewed is responsible for the care and treatment of these women in the maximum security prison. And while the minimum security

correctional facility does have a safe cell, usually women who need the safe cell are transferred to the maximum security facility. So this is an issue specific to the higher security gaol. Not only is the doctor quoted below distressed by the treatment of these women, the doctor raises the issue of the tension between custodial and health care issues. For the doctor, the situation is untenable. On the one hand they are responsible for the appropriate care of these women and, at the same time, safe cell practice is one this doctor opposes on therapeutic grounds.

> **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 and that goes beyond the psychotic illness, to the women who seriously harm themselves and do so repeatedly, that this ought not to be a custodial issue. They argue it is a health issue and we should take the overwhelming responsibility. Yet at the same time, they give me none of the control which is necessary to make decisions that are going to alleviate the patient's predicament. The principal of these are that for us to take over the care of women who are repeatedly self-harming when the predominate management tool is to restrict, in effect punish, these women for any self harming behaviour by imposing what in my view is the most restrictive and draconian practices.
> **KW**: Safe cell practice?
> **Doctor 1, Maximum Security**: Yes. Putting people in white boiler suits and having an officer in one instance sitting there but not allowed to say anything to them, not responding to anything they might have to say, I think that is not only harsh it is grossly inappropriate. Of course it is the very opposite of what we would do if you had such a person in hospital. You have a special nurse with someone repeatedly self-harming. We wouldn't put them in restraints and isolate them; you try to provide a therapeutic atmosphere with caring and compassionate and competent staff who are able to deal with their emotional issues. Yet what's happening here is the *very antithesis of therapy*. And yet at the same time I am being repeatedly loaded up with the responsibility and made to feel quite guilty, that I'm not doing the best by them (emphasis added).

The doctor construes safe cell practice as a matter of professional autonomy: "they give me none of the *control* which is necessary to *make decisions* that are going to alleviate the patient's predicament." But this case also illustrates the clash of institutional goals – between therapy and punishment. "What's happening here is the very antithesis of therapy." Moreover, this case is an example of the problem of the

lack of a team (CHS and DCS) approach to care. Moss[10] addressed this issue in relation to self-harming prisoners in her report (see Chapter 3, section 3.7.3.9).

The second example of professional autonomy being constrained that I will explore is that of a clinician whose clinical judgment was questioned. This case is informative and instructive, because the situation the doctor found themselves in would simply not occur outside the prison context.

> **Doctor 3, Minimum Security**: I hadn't been working here too long, I think I was at [the maximum security correctional centre] and I think I had only been here for 6 months and it was an Aboriginal inmate who, actually did not seem to be particularly unwell, but clinical signs suggested that she had pneumonia. So I decided that she had to go out to have an x-ray. It turned out that at that particular day was the worst day that could possibly ever had to send anyone out for an x-ray and the officer was extremely annoyed because she did not appear to be that ill. I found that I had to ring the Governor and then the Governor had to ring me and I found that I was in the unpleasant situation of having to demand that a person be sent out for an x-ray. With everybody around me saying she was not ill at all. Then after she had her x-ray, she escaped from radiology. Then it was really terrible because then they all started saying "do you realise that dreadfully ill patient who probably had pneumonia had just decided to leave the x-ray facility" and she was gone for several days. I was just sort of hoping desperately that she had really bad pneumonia and luckily for me it turned out that the x-ray was really bad. And it may easily have not been. That was just good luck rather than good management. And so, it let me off the hook really, and when they finally captured her again they had to take her straight to hospital for treatment for pneumonia. It was the difficulty of having to remain strong and stick by your judgment when medical things are often so *difficult to judge*. So I think that it is very hard because at other times it can work the other way, you can actually go against your judgment. I just have to always remind myself if I feel bad about something even though you end up with egg on your face; you just *have to* go with it anyway (emphasis added).

Several unusual things seem to be happening in this case. Uncertainty is part of clinical practice and yet this sits uncomfortably in the prison context. The correctional officer requires certainty, however this may not be possible because, as the doctor states, "medical things are often so difficult to judge." It is unusual for

[10] NSW Ombudsman, *Mulawa Report,* Government Publishing Service, Sydney, 1997.

doctors to be questioned by non-medical personnel, particularly those outside the health care system. In this case the custodial officer questioned the doctor's decision. In everyday health care practice ordering a chest X-ray for a patient with suspected pneumonia is a routine practice. Pneumonia is diagnosed by clinical signs and X-ray. The doctor's clinical judgment and professional autonomy are being called into question because of logistical and security concerns. What is evident in this case, as with the previous case, is that it is an example of the clash between institutional goals: therapy and security.

5.3 Personal impact

In this section I will discuss clinicians' feelings about what it is like to work in the prison context and to work with inmates. I will also discuss the strategies and methods used by practitioners to manage difficult patients.

5.3.1 Personal Impact of Context on Clinicians

The next two themes discussed relate to how working in the prison context and having prisoners as patients personally affects clinicians. The key points to emerge from the health care practitioner's narratives about the prison context were: an overwhelming sense of frustration and powerlessness; and feeling frustrated and annoyed by situations beyond their control.

One example of consistently frustrating situations was getting specialist appointments for patients. There are several reasons why this was a frustrating process. According to participants, patients must be escorted from the prison to the referral centre/hospital

by correctional staff. Escorts are limited to two per day. Usual practice involves patients having appointments made for them by the clinic staff and, when these are due, they are escorted by custodial staff to their appointment at the public hospital. Urgent cases take precedence, so a patient may have their appointment cancelled at short notice because another patient must be transferred to hospital urgently. This causes a great deal of frustration for both patients and clinicians. Here context exacerbates an existing systemic problem.

> **Doctor 1, Minimum Security**: They [inmates] have to go to hospital for those services and sometimes it is twelve months wait. So they might be waiting twelve months to get in to see a specialist about something and on the day of the appointment they find that after waiting twelve months to get in to see a specialist there are a couple of emergency cases in the gaol and their appointment gets cancelled. So they've got to wait another twelve months and that quite frequently happens, it's not uncommon. It's frustrating!

Another problem raised by clinicians was that they believed specialist and hospital staff do not appreciate the logistical problems faced by practitioners working in prisons. The problem of feeling isolated both geographically, and in terms of clinicians outside correctional contexts having little understanding of the role and problems faced by those in correctional contexts, is documented in the literature. Furthermore, outside consultants have expectations that patients will arrive at a certain time and, as practitioners, they expect to be treated with respect. They do not understand the difficulties organising escorts and with prisoner patients. Some outside consultants when confronted with difficult prison patients have, on occasions, refused to treat any more prisoners.

> **Doctor 3, Minimum Security**: I think some of the inmates are very much in your face and they can be very intimidating. A lot of medical professionals have trouble with that. Staff here are used to it and just the way people are, you just let that go, you just have to let them let it out. But it doesn't go down well with them.

Another source of frustration was the 'double standard'. The nurses at the minimum security prison noted that if inmates behaved badly towards custodial staff they were disciplined. If inmates behaved badly to the nursing staff, however, inmates were not disciplined by the correctional officers. The nursing staff did not have any moral difficulties with the idea that there were consequences if inmates behaved badly; but they did resent that custodial officers did not discipline the inmates when they behaved improperly towards nursing staff.

> **Nurse 4, Minimum Security**: We get a bit annoyed at the different standards. If an inmate is abusive to an officer or doesn't attend a muster they get charged, whether it is off buy-ups or off phone calls or something. There is some consequence. But for the nursing staff here, because we are not employed by DCS, if something occurs here it is dependent on which officer wants to take care of it. We will write a report and sometimes we get a bit pissed off, because it's like "Oh fucking nursing staff."

5.3.2 Personal Impact of having Prisoners as Patients

As one would expect, the nursing and medical practitioners interviewed expressed a variety of feelings about the experience of caring for prisoners. This ranged from very positive experiences and feelings of satisfaction to negative experiences and feelings of fear, and even hatred. The nurses interviewed were more likely than the doctors to express negative feelings about patients. In the main, the doctors had positive views about their patients while the majority of the nurse participants felt frustrated, angry and resentful. Arguably, this reflects the amount of time the nurses spend with inmates.

> **Nurse 3, Maximum Security**: I had a lousy night, on a Sunday night, I was nearly in tears, and I'm beginning to hate them. I don't like hating patients.

Several of the doctors spoke about feeling guilty about the nursing staff. They noticed that patients were much more inclined to behave abusively towards nurses.

Nurses bear the brunt of patient anger and they report feeling angry and unsupported. The following extract also highlights the gendered underpinning of the division of health care labour.[11]

> **Doctor 3, Minimum Security**: I think as a [doctor] here I am quite protected, the nurses go to a lot of trouble to protect me and take a lot of flack on themselves, it is very supportive working with them and the patients maybe a little scared to take it out on the doctor. In a way it is feels like the opposite to me, I feel a little bit bad when I see the patients being so aggressive and horrible to the nurses and then so smarmy and sweet to me... I feel guilty that I don't support the nurses more...

Overwhelmingly practitioners expressed concern about their patients, not only in terms of how best to manage their patients' health care concerns, but also at a more personal level. By and large practitioners wanted their patients to do well, and they hoped their patients would be able to leave prison and not return. At the same time, some practitioners recognised that their patients were kept safe in prison. Outside they were at risk, but inside they could be cared for.

Some practitioners also expressed concern over their own safety. This was particularly true of less experienced nurses. One nurse was worried about the lack of security in the minimum security correctional facility.

> **Nurse 4, Minimum Security**: Alright, um well with the abusive patients, sometimes it can be hard to deal with them and you have always got an officer who can step in, but I have found like its more relaxed here, whereas in the maximum prisons ... officers will step in more readily than here, so I find that a little bit hard sometimes, I think officers should always be here with an inmate, cause you never, just because we are a minimum security gaol it doesn't mean they are not going to do something to us.

Some practitioners felt fearful of their patients.

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[11] Game, A. Pringle, R. *Gender at work,* Allen & Unwin, Sydney, 1983; Wicks, D. *Nurses and doctors at work: rethinking professional boundaries,* Allen & Unwin, Sydney, 1999.

Nurse 1, Minimum Security: This girl said "I've got really, really bad toothache" so they [the dentist] saw her, got her in the chair, there was not a thing wrong with her mouth and she said "Oh no I just wanted a check up", so the dentist said "well I'm sorry I can't do that now." The girl just went absolutely berserk, threw instruments that were on the tray at the dentist who was a very slightly built pregnant lady, [the dentist] lost the plot and was terrified, and the dental nurse, they were just terrified. The altercation was very loud, and there was an officer in the clinic sitting at the desk reading pornography and stuff that he reads. He didn't even come to their aid until somebody asked him, and then he comes and sort of says "Oh well you know and what do you want me to do about it. Make it in a report?"

Feeling fearful about patients was not restricted to nurses.

KW: have you ever been concerned for your safety or security?
Doctor 2, Maximum Security: There have only been two, there have only been two episodes, and both were associated with someone who was very ill, she is probably going to die from the Hep C. She has got liver failure and she stands over people. She threatened to attack one of the psychiatrists, she stood over the nurses for pills ... but she was really quite crazy and I actually got one of the nurses to stand in with me. The other occasion was with one of our chronic self mutilators. It is very, very sad, she has tried to hang herself a number of times and has been really bad and discharged from psychiatric hospitals because her behaviour is so bizarre and inappropriate. And one of her mutilations was she actually put a staple into her skin and because she was behaving so badly at this stage they didn't want to send her out to hospital to get this removed. I had seen her a number of times about health issues and always tried to treat her with respect and fairness and I said to her "Look I am going to be using very sharp things if you do anything that is assaulting me I am going to stop."

The experience of being lied to and manipulated was concerning to a number of practitioners. On the one hand, clinicians wanted to trust their patients and think well of them; on the other hand it would be extremely naïve to think the patients would not want to 'scam' them. Patients manipulate both medical and nursing staff for medical certificates related to prison work, medications – sleeping tablets and analgesics in particular - and food. Prescribing medications was a particular concern for the medical practitioners. Some prisoners are especially inventive with prescription drugs and use them in ways other than intended by the prescriber. For example, in prison there is a market for Buscopan and Indocid suppositories are melted down for

intravenous use. Both these drugs are quite usually and frequently prescribed for muscle cramps, and joint pain respectively. Some drugs have other uses in prison.

> **Doctor 1, Minimum Security**: In terms of dispensing medication you need to decide what can you use safely, who you prescribe it to, whether there is a supermarket or not, which is a very subjective call. And some medications like this one with the chest pain, I wanted her to have Isordil and I was told you could make a bomb out of that.

One nurse had a particularly bad experience of being persecuted by a prisoner. This created enormous problems for all the nursing staff at the minimum security institution, but particularly the accused nurse. In this case, the usual checks and balances for ensuring prisoners are properly treated and that those caring for them are accountable worked against the nurse. There was no evidence to suggest the nurse had behaved inappropriately towards this patient, indeed the nurse was exonerated. The situation was eventually solved by transferring the prisoner to another facility.

> **Nurse 2, Minimum Security:** When it gets to that level you get fearful of practising as a nurse. That is probably one of my biggest ethical issues here. I have had a woman go me daily with blueys that are complaints, they write on a bluey. She wrote to the Minister, she wrote to the Ombudsman, she wrote the Commissioners, disgusting lying stuff.... I can't even go into the examples they were so awful. All of us she went, but me she picked on. And it went on for weeks, and I rang the Nurses Association and they said its part of being a nurse. I said this is so damaging I am a mess, I am becoming a mess. I rang CHS administration and they said to just answer the complaints. And they would be coming off the fax because they would go to the Minister's office and the Minister would send them to the Governor here and the Governor would hand them to me. I would be taking one across to answer it and all the officers knew of them too because it would get passed around and they would laugh because they were so ridiculous. I was humiliated and eaten away, and I just burst into tears and said I can't cope with it. *The Governor was very supportive and gave me the best support.* My own department were not very helpful (emphasis added).

Whilst not overtly expressed, the sense of being *resigned* was evident. Practitioners understood that they cared for patients who were largely unappreciative of their efforts and who were at best indifferent to their own health care needs. Caring for

inmates appeared a thankless task. Some of the clinicians were resigned to being unappreciated, some more philosophical. One nurse related how patients never expressed appreciation or even recognition for all the work done, but this nurse took heart that she could joke with a patient who had been so aggressive in the previous encounter. Practitioners then, gained satisfaction for their efforts in other ways.

> **Doctor 2, Maximum Security**: You can only find satisfaction from very, very small issues and I think there is always a very clear division between what the inmate's issues are and what I would perceive their health issues are. They want more specific responses, they want to see the dentist, they want to get a bad tooth out; they are not so much focused on their hepatitis C. If I do see someone who has recently come in they are hanging out, you know that they are not wanting to talk to someone about their issues or why they started to use drugs. I guess the bottom line is if I have an interview or an interaction where I have treated someone with respect and they've paid attention to that, that's the best I can do, there's no way that I can resolve their issues.

5.3.3 Ways of Dealing with Problematic Patients

Given that nurses have more dealings with patients, they were the ones who had to formulate formal or informal ways of dealing with problematic patients. Nurses developed several strategies for dealing with abusive and violent patients. A common strategy was to physically distance themselves from the patients and give inmates time out to cool down. A common way to do this was at the point of the most tension: the pill window.

> **Nurse 3, Minimum Security**: We close the window sometimes and just say "Look we are just closing the window a moment and we will be back in 5 minutes" or we will say to someone Look we are not getting anywhere, how about you go away for 5 minutes and then come back."

Another strategy was to try and normalise behaviour. Nurses would start out trying to talk the violent and/or aggressive person into calming down. If this strategy did not work then others were employed, until discipline was restored.

Nurse 4, Minimum Security: You've got to calm them down, you just talk calmly with them, explain. So if they want sleepers for the night and you can't give them to them, you explain that that is not our protocol or our policy and you give them techniques of what they can do instead of taking the sleepers. And if they are really abusive we will either tell them to come back later when they've calmed down, or shut the windows and close the door, or at worst get the officers to step in.

5.4 Summary

This chapter reported *inter alia* on the central themes relating to ethics and professional values articulated by clinician participants. The ethical principles and values expressed in the bioethical texts and CHS *Professional and Ethical Guidelines* were evident in the clinicians' talk about ethics. Clinicians raised issues relating to the moral principles, values, and virtues, and the rules of the practice. Of interest to this thesis was that clinicians expressed difficulties fulfilling almost all of their ethical and professional obligations to patients. This was primarily the case because health care concerns were, in the main, subsumed or subverted to custodial concerns. Thus the prison context renders clinicians' ability to fulfil their ethical and professional obligations to patients at least problematic, and in some cases, impossible.

The experience of working in the prison context was a frustrating one. Clinicians reported feeling frustrated, annoyed, dissatisfied, and angry over situations in which they were unable to care for their patients properly, and in which their clinical authority was questioned. The experiences articulated by participants support Goffman's observation that professionals working in total institutions feel dissatisfied because their professional goals are not only antithetical to institutional goals they are subordinated to them.

Practitioners experienced a range of feelings towards their patients. Clinicians were clearly concerned about their patients' health problems and their welfare. Most of the clinicians were moved by their patients' terrible life narratives. Some of them expressed genuine liking and respect for their patients. Others felt resigned and hopeless when faced with so many manipulative and untrustworthy inmates. Many of the clinicians recounted stories of feeling unsafe and afraid of unpredictable and violent patients.

The nurses interviewed more likely to express negative feelings about their patients. This is a result of the amount of time spent with patients. Moreover, the division of health care labour in which structures work around gender norms is evident in the data.

Clinicians' experience of caring for prisoner patients will, in part, make up the content of the next chapter. In analysing the social context of the prison I will report on data which explores relationships between clinicians and their patients as well as their relationships with DCS staff, and other health care professionals.

Chapter Six: The Social Context

6.0 Synopsis

In this chapter I will continue to report the interview data, specifically themes that relate to the prison context. This chapter deals with the social context. The social context refers to persons and groups which the health care practitioners referred to and, in the main, dealt with on a regular basis. The first group discussed in this chapter are the patients. Secondly, I will discuss groups broadly categorised as other occupations. This includes other staff members of CHS, especially its Administration. It also refers to DCS staff who either work in close proximity with participants, or whose influence impacts on the provision of health care to prisoners. Included in this group are correctional officers, the prison administration, other professional groups employed by DCS (eg. psychologists), and probation and parole officers. Providing reports and other information to magistrates and some members of the legal profession are also within the ambit of some of the health care professionals interviewed. In their role as primary and secondary health care providers to women prisoners these practitioners must liaise with hospital and specialist staff in other institutions. The data suggest that relationships with patients and other groups raise ethical and professional complexities, including the problems of acculturation and dual loyalties. Moreover, the requirement for health care professionals to adopt a security role which is incompatible with their ethical and professional duties to patients distorts the practitioner-patient relationship.

6.1 Prisoners as Patients

Health care professionals working within correctional centres have prisoners as patients who, along with patients in any context, are owed a duty of care. Caring for patients in the prison context, however, is not unproblematic or straight forward. Providing nursing and medical services in the prison context is challenging for a number of reasons. As noted in Chapter 3 women inmates have complex and a broad range of health problems. Many of these conditions are exacerbated by incarceration. Moreover, clinicians must cope with the difficulties posed by the patients themselves. The patients' tendency towards problematic behaviours impacts on the provision of health care and on health care providers. In the following sections I will consider specific patient groups cared for by the health care practitioners interviewed, and indicate how prison exacerbates their condition.

6.1.1 Mentally ill patients

According to the 2001 inmate health survey of sentenced female prisoners, 5.6% suffered from psychosis, 20.4% had an affective disorder, and 54.5% had an anxiety disorder, with 59.2% of female prisoners suffering from a major mental disorder.[1] Prisoners are significantly more mentally disordered in comparison with the general population. Moreover, patients suffer because they are imprisoned and they suffer because they are unable to care for their families.

> **Nurse 2, Maximum Security**: We have a lot of diagnosed mental illness and we also have a lot of mental health issues that are not necessarily a diagnosed such as minor depression. [They have] lot of the dark thoughts and they self harm. They get distressed when things are happening out in the community that

[1] Butler, T. Milner, L. *2001 inmate health survey,* Corrections Health Services, Sydney, 2003 cited in Butler, T. Allnutt, S. Cain, D. Owens, D. Muller, C. Mental disorder in the New South Wales prisoner population, *Australian and New Zealand Journal of Psychiatry,* 39, 2005, p.410.

they have no control over. It's a big part of our daily activities, mental health actually.

Many resources from both CHS and DCS are involved with caring for patients with a mental health disorder including preventing them from harming themselves, particularly in the maximum security correctional centre.

Doctor 2, Maximum Security: There is a mental health team and there's a huge parade that goes on in the morning which is the risk assessment team, like for women who are at a risk of self harm and suicide, so a lot of times that is a team that is going through that, there is usually a mental health nurse there in the morning and afternoon, and at the moment there are the psychiatrists that that come in and they have got a psychiatric registrar who is working really, really hard.

Spending enough time with patients who suffer from a mental illness is an ethical issue about community equivalence for health care practitioners who work directly and specifically with psychiatric patients. This situation is further exacerbated by prison overcrowding as previously reported.

Doctor 3, Maximum Security: Yes, I find that even spending time with them is therapeutic, I mean the first interview I'll have will last a long time, about an hour, an hour and a half. In that time I build a rapport with them, and subsequent times when I see them see them, I try to see them every two or three weeks, subsequent interviews are usually about 10-15 minutes only because I don't [have the] latitude to spend longer. But I find it is all I really need, just to touch base, see how they are, where they are at, if they need longer of course I will spend longer, sometimes with some women I do have to spend a longer time and I do give them half an hour, an hour sometimes. But usually 15-20 minutes is all that I need.
KW: Would you like to see them more often?
Doctor 3, Maximum Security: I find that that is all I can give them, that's all I can give them.

Butler *et al*[2] argue

While prison is an unsatisfactory environment in which to treat those suffering a mental illness, the relatively lower prevalence of mental illness in the sentenced group suggests that imprisonment may be an important treatment opportunity

[2] Butler *et al*. Mental disorder in the New South Wales prisoner population, *Australian and New Zealand Journal of Psychiatry,* 39, 2005, p.410.

for the mentally ill. We do not, however, advocate imprisonment as a therapeutic option.

The health care practitioners interviewed for this research would agree that in some cases imprisonment provides a treatment opportunity for patients. The data, however, demonstrate that those health care professionals who care specifically for mentally ill and disordered patients make finer and more nuanced distinctions between mentally ill patients and the benefits of imprisonment. The following extract demonstrates this point.

KW: Do you think the women here get the same care as they would on the outside?
Doctor 3, Maximum Security: That's an interesting question; again we are looking at different levels. For instance the girls here at the [special unit] definitely won't have the same care that they would have in a hospital setting, definitely not... their treatment would be sub-optimal as opposed to a hospital. However, you will find that another population of girls would have better care here than outside. Those are the girls that are into the self-abuse; the girls that perhaps in the community only have an overnight stay for drug induced psychosis and discharged the following day without follow-up. Here they are detoxed off substances, the ones we see on a regular basis, we have them on medication, we have supported therapy with them, and they are seen every 2 to 3 weeks, where as on the outside they would not be seen at all. So you just have different populations, the ones that are more seriously ill should not be in prison; they're the ones that have sub-optimal care, where the other ones have probably better care than they would have outside.

The following two cases represent ethical issues with treating patients with a major psychiatric illness who would be better cared for in a psychiatric hospital rather than in the correctional context. The first describes the case of a patient who suffered from a bi-polar disorder. It not only illustrates ethical issues about caring for the mentally ill in the correctional context, it also illustrates a systemic failure of the mental health care system to provide appropriate care to patients.

Doctor 1, Maximum Security: There one woman who I treated on two occasions. She has a bi-polar affective disorder, she initially came in because she was in hospital and she just left the hospital psychotic and manic and she failed to pay a taxi fare of $20.00 and because the taxi driver got angry she

threw a flower pot on the car and she did a bit of damage to the bonnet. He went off and called the police. The police came up and seized her, she resisted arrest she got a charge of malicious damage, failed to pay fines and assault and causing malicious damage x 2.

When she came here she was manic, she was acutely psychotic, she was very ill and she was so ill we had to enforce medication which we rarely do. So we gave her Olanzapine. Again giving a medication like that which is anti-psychotic, it's an injection, and this medication can really need close observation with regular monitoring of pulse, and blood pressure and so forth. It causes hypotension, and this can be potentially severe and of course in these situations it is very precarious, so we have her in a camera-ed cell. The observations are not as close as they would be in a hospital situation and so this was an important issue for me. Afterwards we treated her with anti-psychotic drugs and we put her on a mood stabiliser and she became well. I had to call her solicitor and ask him to ask me for a court report because I thought she needed one, otherwise he wouldn't have asked for one and she would have slipped through my fingers. I asked him, please this woman needs a report, please request one. So he requested it through the appropriate channels and I wrote the report and she was released, released on bail and I sent in recommendations that she needed to be followed up in the community, the sort of things she needed to have, regular medication, and so forth. Unfortunately that wasn't followed through and she stopped taking her medication and within 2 weeks she again re-offended. Again her re-offending was very trivial, I think she threw some water at the neighbours and they called the police, and she started spraying water at the police and so she came into prison.

I really find this case difficult. She was actually sent to hospital for assessment, and the hospital turned her back and said, "Yes she is psychiatrically ill, but we don't have any beds". So she was sentenced to prison and we treated her in prison, and again we had to enforce medications, again she got better. The second time when she went to court and I called her solicitor, I called the Community Mental Health Team and I told them this women needs to be put on depo-medication, she needs to be followed up in the community and the Community Mental Health Team said "Well we know her very well, and we don't think we can offer her anything." And this I find very difficult because she gets better care in prison than on the outside. [Treating her in prison is] not appropriate, and it needs to be handled in the hospital system and in the community. Instead of going into hospital they come into prison.

The second case describes the situation of managing patients with complex health care problems in a context where the ready availability of necessary, technical support was not available.

Doctor 3, Maximum Security: I have a patient who has a psychotic illness due to her chronic epilepsy. Her crimes are not trivial, they are significant crimes but she did them while she was psychotic... She is on three different anti-

epileptic medications, and I've introduced anti-psychotic medications to treat her psychosis and I find that I am having to do a little balancing act here because every anti-psychotic medication lowers the seizure threshold so what we are doing is trying to have her medically stable so she doesn't have seizures at the same time to have her psychosis under control. And this is a situation for a hospital not for a prison.

6.1.2 Drug and Alcohol Addiction

The clinical and penal issues surrounding inmates' use of both illicit and licit drugs have been well documented in the literature and discussed briefly in Chapter 3. The vast majority of incarcerated men and women have a history of drug use and this has clinical consequences for health care practitioners and their patients. Clinicians are responsible for the health care of drug addicted women, who are sent to the maximum security correctional centre from the court on remand and prior to their next court appearance. Health care staff must treat and comfort patients who are trying to cope with the side effects of drug withdrawal, as well as being in prison. This is also ethically problematic because the judicial requirements and procedures override the health care needs of patients.

Nurse 3, Maximum Security: Now, a girl comes in from court, late at night, and withdrawing badly. There are a lot more serious drugs on the market now, we've got the ice, which is the heroin cocaine and amphetamine combined, and the withdrawals are hideous. They can be called to court the next day, and there are still hanging out badly. I give them medication.
KW: Are you saying that the police and court procedures are unresponsive to the patient's health care needs?
Nurse 3, Maximum Security: I do feel that they should not be remanded the day after they come in because they can be waiting in what we call the cage for four hours before we have time to sedate them and they vomit they aren't fit to go to court but they have to.

Inmates with a history of heavy drug use exhibit all the attendant complex clinical problems. Moreover, patients, particularly those with a history of intravenous drug use, frequently arrive in the correctional facility in poor health because they tend not

to access health care outside prison. These patients have complex health problems related to their drug-taking behaviour, which may go under-treated prior to incarceration. Many of these patients do not have resources to access dental care when they require it. Moreover, and more importantly, many women who are drug dependent do not place much importance on health or dental care: they have different priorities. The relative lack of importance and emphasis on their own health care creates difficulties, clinically and ethically, for health care providers.

> **Nurse 1, Maximum Security**: Probably up to 60 to 80% - a fair number [take drugs]. You find that the ones who have got an IV using past tend not to access health care, their teeth not at all, [they are] stumps basically [because] Medicare does not fund dental care, so it's certainly a back seat for the girls. So that would be really, really, at the bottom, dental care.

6.1.3 Aboriginal patients

Aborigines are disproportionately represented in the prison population, and this holds true in the women's prisons. Commissioner Wootton's 1991 report *Royal Commission into Aboriginal Deaths in Custody*[3] investigated the deaths of Aboriginal men in police custody in three eastern Australian states – NSW, Victoria and Tasmania. Wootton argues that the reason why many Aborigines die in custody is because "so many are locked up in this country."[4] They are disproportionately incarcerated, Wootten explains, due to a history of racism, institutionalisation, inequality and cultural misunderstanding.

Wootten, during his investigation into the health of the men who died in custody, found that their health was notoriously bad. Moreover, many Aboriginal people felt

[3] Wootten JH. *Royal Commission into Aboriginal Deaths in Custody, Royal Commission into Aboriginal Deaths in Custody: Regional Report of Inquiry New South Wales, Victoria and Tasmania,* Sydney, 1991. Available at http://www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic/ accessed 19.6.06.
[4] *Ibid.*

alienated from mainstream health care services. He found that the health care services, particularly those in remote communities were deficient, white-dominated and inclined to "close their ranks rapidly on a racial basis".[5] With regards to health care provided in the prisons by the then Prison Medical Service, Commissioner Wootten found in particular cases that the medical staff had no special expertise in caring for Aboriginal patients. He recommended that the expertise of the Aboriginal Medical Service (AMS) be extended to Aboriginal patients in prisons. In the two prisons I visited, Aboriginal women are cared for by doctors employed by the AMS.

Many of the doctors and nurses interviewed for this study recognised that providing appropriate care to Aboriginal people was an ethical issue in terms of the overrepresentation of Aboriginal women in prison, the need to provide culturally appropriate health care and because of racism in prisons. Racist treatment of Aborigines, as well as the overrepresentation of Aboriginal women in prisons, is the reasons why the doctor, in the extract below, considers Aboriginality an ethical issue.

> **Doctor 2, Maximum Security**: Aboriginality is always an ethical issue and we have a large percentage of aboriginal girls in the prison. I wouldn't know the figures, but we do have a lot of aboriginal girls and the aboriginal girls quite frequently have been in and out of prison. So it is an ethical issue. I think that the staff do try their best to address the issue appropriately and sometimes the girls do use that as well. So but it will be an ongoing ethical issue.

The poor facilities and lack of resources which obtained at the maximum security correctional centre and, in the past, at the minimum security facility were of concern to the health care staff. This was particularly true for Aboriginal patients for cultural reasons.

> **Doctor 3, Minimum Security**: I found it very hard when I first arrived. The facilities were not good enough. I think that was an ethical dilemma too, at one

[5] *Ibid.*

point I remember we were in a really atrocious building and there were no curtains round the bed, if you opened the door there was a woman having a pap smear. Half the time if you need a swab or whatever, you could not find it. We did not even have a sink in your room to wash your hands; you would have to leave the room to wash your hands, meanwhile being unable to guard the door to stop anyone walking in. You really felt like you were offering women a very poor service which upset me particularly for the Aboriginal women because I could see exactly how culturally inappropriate it was for them. And that was an ethical thing. By working there are you supporting a bad system, or are you helping them because you at least are trying to provide a good service?

Following Commissioner Wootten's recommendation that culturally sensitive and responsive care be provided for Aboriginal patients, the AMS employs medical practitioners who run clinics at both the maximum and minimum security correctional centres I visited. The health care staff interviewed saw the provision of health care by medical practitioners with expertise with Aboriginal patients as a good thing.

Nurse 2, Minimum Security: We are really lucky we have an AMS parade and the Koori girls get that access of a morning every week.

Respondents believed that the medical staff working with Aboriginal patients were able to provide better continuity of care to their patients because Aboriginal patients were seen by the same doctor.

Doctor 2, Maximum Security: There is an aboriginal clinic on Thursdays that has more continuity than what my job ever has.

Trust, so important in the clinical relationship, is particularly central to the care of Aboriginal patients. Participants in the research not employed by the AMS believed that Koori patients overwhelmingly preferred to be seen by the AMS practitioner. In fact clinicians not employed by the AMS had very little to do with these patients.

Nurse 1, Maximum Security: Not the Koori girls, they actually prefer to talk to the Koori doctor. ... We don't see the Koori girls very often. They rarely access us to be honest.

While it was generally recognised that the Aboriginal clinic was good for Aboriginal patients, it was not without controversy. Aboriginal patients have easier access to their medical practitioner because they do not have to make appointments at the 'pill window' unlike other prisoners, and, as already noted, have better continuity of care. The easy access to medical practitioners, and particularly not having to make appointments, was a source of resentment for some non-Aboriginal patients. One practitioner interviewed who was in favour of specific clinics for Aboriginal patients noted that this situation could easily be manipulated by non-supportive health care staff members.

> **Doctor 3, Minimum Security:** The Aboriginal clinic is in place so that they have easier access to medical care. They do not have to make appointments where other patients do, and that can be a source of upset to other patients because they have to be triaged by the nursing staff... We had a staff member who did not really support Affirmative Action for Aboriginal people and managed to twist it around that Aboriginal people were only allowed to see me, not the other doctor. So she decreased their liberties, and it just shows you the sensitivity of the Aboriginal people, that they really swallowed it hook, line and sinker. They believed that having special clinic was a form of discrimination against them...

6.1.4 Misplaced Persons

While not an official term, the idea that prisoners were 'misplaced' or 'lost' was evident from a number of the interviews and in an assortment of ways. The first group of misplaced persons were incarcerated mothers and their children. Health care practitioners reported that mothers and babies in prison raised special ethical concerns. The second group of misplaced persons were those who had escaped from the correctional facility. Misplaced, escaped persons are problematic because they may miss vital medications.

The issue of pregnancy, mothering and children is complex and difficult in the prison context. Incarceration, for most women, means being separated from their children. The doctors working at the minimum security facility were particularly aware of the anguish women prisoners felt about how their behaviour and incarceration impacted on the lives of their children. For these health care practitioners, this was both a clinical and an ethical issue. Women prisoners worry and feel guilty about leaving their children, about how they previously treated them, and about neglecting their children. They also worry whether their children will forgive them. The guilt experienced by many mothers in prison leads to health care problems: trouble sleeping, mental health issues and drug seeking behaviour to blot out their feelings of guilt.

Some women have the opportunity to have their babies and/or small children with them while they serve their prison sentence. In the minimum security correctional facility, a mothers and babies programme has been set up to allow for children under five to stay with their mothers, providing the mothers had the appropriate security classification. The safety of the children is a central concern of the programme. These women are monitored much more closely than they would be in the community to ensure they remain drug free and psychologically fit. Health care practitioners have a surveillance role with these mothers.

> **Doctor 1, Minimum Security:** Mothers can have their children with them if they have no other carer to look after them. We watch the children and we watch the women. We drug test the women to monitor their psychological well-being and if we are in doubt about whether the child is at risk then they are removed. Under the age of five there are some certain circumstances in which they can have their children with them and we can refer on the older children when they are on weekends or on holiday.

The care of pregnant women is the responsibility of the nursing and medical staff at the two prisons. The health care practitioners interviewed, who are largely responsible for the ante-natal care of these women, argue that they receive better continuity of care than women who are not pregnant. Moreover, participants agree that pregnant women in prison receive better ante-natal care than they would on the outside. This idea is supported by research.[6]

> **KW**: Do pregnant women get good health care?
> **Nurse 4, Minimum Security**: Yeah, because if they were on the outside, you don't know what kind of drugs they would be using... And they might not follow up appointments, whereas the appointments are made here and *they are made to go* (emphasis added).

Some patients, though, prove recalcitrant and cannot be made to keep appointments.

> **Doctor 2, Maximum Security**: The pregnant people I see most of them, there's one Aboriginal girl at the moment who I called up three times and she never comes. I have a big issue with her because I haven't seen her for so long.

Health care professionals working in the maximum security prison are not only responsible for the health care of women who have been sentenced, but also women on remand. Pregnant women on remand pose particular problems for those responsible for their ante-natal care. Once a woman is sentenced she is given a security classification based on her crime and previous gaol history if any. Women with a low security classification may be transferred to a minimum security correctional centre, and pregnant women with a low security classification may be eligible for the mothers and babies programme. While women are on remand they cannot keep their babies with them. It matters to the health care staff responsible for ante-natal care at the maximum security facility that these women are sentenced in a timely manner, so they can keep their babies with them.

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[6] Martin, SL. Kim, H. Kupper, LL. Meyer, RE. Hays, M. Is incarceration during pregnancy associated with infant birthweight? *American Journal of Public Health,* 87:9, 1997.

Doctor 2, Maximum Security: Well, it is very difficult, I guess I spend a lot of energy really hoping that they get sentenced and they are eligible for mothers and babies programmes, to do that they actually need to fit certain criteria.

Some of the problems faced by women on remand with babies are illustrated in the case below. The woman was trying to maintain her breast milk, but this endeavour was made almost impossible because of corrective services policy with regards to prisoners exposing themselves to male staff. Goffman's[7] description of the treatment of inmates as 'batch like' and institutions being inflexible seems apt here. Legitimate individual needs which deviate from established routines, even ones as basic as expressing breast milk, cannot be accommodated in total institutions. Alford's[8] data which show that power over inmates is exercised by not caring is also evident in the following case. The woman's need for privacy could be easily accommodated by the custodial authorities.

Doctor 2, Maximum Security: A woman I was seeing on Tuesday she's got an 8 week old baby. She is the first child, her partner has drug and alcohol issue, he's not well enough to cope with the baby, so she had actually given care of the baby to his mum for a temporary period hopefully. But then she is trying to maintain her breast milk until the baby comes back and hopefully she will be able to be sentenced and eligible for mothers and babies [programme] and have the baby with her. But she is getting no support from the gaol about needing to be somewhere where she can express milk because they're short staffed, if she exposes her breast in front of a male officer she can be charged ... and there are very good reasons [for that]. She was working in what they call the chook shed, which hasn't got any chooks, but they call it the chook shed. She is locked in there with all these women who are smoking all day, she is a non-smoker and she has no opportunity to express milk.

The second group of misplaced persons are those who are lost or escaped. Misplaced patients were ethically problematic because they missed treatment and usually medication while they were at large. If they cannot be found in a timely manner, they might get into medical difficulties. The story cited below contains several ethical

[7] Goffman, E. *op cit.*
[8] Alford, CF. *op cit,* pp.126-7.

issues: the patient's need for methadone, and the public health concern over an HIV positive patient potentially sharing needles. The nurse is most exercised, however, by a confidentiality issue: how much can be disclosed "out of the service".

> **Nurse 2, Minimum Security**: One instance was a HIV girl [who] escaped the other day; she was on 90m milligrams of methadone, which meant she would be hanging out. My decision as a nurse was to notify the doctor, but what prompted the notification wasn't her HIV status it was her need for her methadone. We had no obligation to tell DCS even if she did phone us. It's not even DCS business. To find her it is a police event. Then there is the issue that she's HIV positive, so she doesn't want to be out there using. It was a public health concern. She was from this area so I contacted [the local doctor] and I said JD has escaped, so if she fronts up there she needs to be back on her methadone. I started getting into grey areas there, thinking I don't know how much I can tell out of the service, and really hoped the doctors would do it.

6.1.5 Illiteracy

The high numbers of women who were below normal intelligence and who were illiterate were discussed in the health survey[9] and raised as a problem by staff in both the maximum and minimum security correctional centres. Illiteracy was seen as problematic for two reasons. The first reason was ethical: some practitioners noted that these women were overrepresented in the prison population, and thus this represented a social justice issue.

> **Doctor 1, Maximum Security**: The majority of inmates are probably of average intelligence. What we have is a greater preponderance of women in the seriously dull/normal borderline range of intelligence. There are a number of women here with intelligence in the 60-80 range. Quite seriously impaired, barely able to read or write very limited vocabulary in terms of verbal fluency. And in the community they should represent no more than 3% but in gaol they probably account for 20% of the inmates. And that's a serious problem.

Secondly, illiteracy and poor levels of understanding of many incarcerated women posed problems for health care practitioners in terms of communication, and the time needed to explain health care problems to these patients. These problems may impact

[9] Butler, T. Milner, L. *2001Inmate Health Survey,* Corrections Health Services, Sydney, 2003.

on the health care choices made by the patients, and certainly undermine their ability to consent. Thus autonomy and consent are issues.

> **Nurse 2, Maximum Security**: I say "How are you at reading?" And they say, "I can't read or I can't read that". Not a lot, but too many. It's harder work to explain in ways they can understand.

6.2 *Patient Behaviours which Impact on the Provision of Health Care and Health Care Practitioners*

Systemic problems are not the only issues clinicians face. In the following section I will describe patients' tendency toward problematic behaviours and attitudes. I will consider the impact of these behaviours and attitudes on the delivery of health care and on the clinicians who were interviewed for this research.

6.2.1 'Juvenile' Patients

Many of the health care practitioners interviewed remarked that their patients, by and large, acted like destructive and undisciplined children. They maintained their patients respond to situations in inappropriate ways. Moreover, the patients lack the skills – both emotional and practical – which mark adulthood and its attendant responsibilities.

> **Nurse 1, Maximum Security**: They do not have much restraint. They blow their stack, they leap before they think. We've had a couple of girls here, some of them in their 20s and 30s, and I think they've got children, and they're like children themselves. I feel at times like I'm dealing with a juvenile, it's like they've never grown up. I've been in with the psychiatrist a couple of times and they've said what did I think and I said I feel like she's a juvenile, she hasn't grown up, she's got no parenting skills, she's got poor communication skills, she's no cooking skills.

Those inmates whose behaviour is, as the nurse above put it, juvenile, presents health care practitioners with very obvious problems. Like children, they tell tales. Several of the doctors told how their patients complained bitterly about their treatment, or lack thereof, by the nursing staff. Yet it was evident to the doctors that the care the nurses provided was very professional, indeed "wonderful". Childish behaviours also hindered some of their patients' ability to benefit from preventative health programmes. Lack of discipline, motivation, education and becoming easily bored meant that these programmes were less effective.

> **Nurse 1, Maximum Security**: I definitely see it in my role [to run such programmes], but would it be productive? That's the thing, because most of these girls aren't conducive to education. It has to be a really thought out program that would suit a young person, like they do in Juvenile Justice. I'd probably be looking at their sort of program at this level of clientele. A lot of the programs [preventative health programmes] that we run are too much for them. They cannot cope with them.

The observation that the inmates were childish was common, certainly with nurses. One nurse also reasoned that their childish attitudes and actions were the result of their level of intelligence.

> **Nurse 4, Minimum Security**: You can tell they're not, oh I don't know how to put it, they're not all there, because they are impulsive and they act like children. They will come up here every day and there will be a new problem, yeah, a lot of the girls aren't intelligent.

6.2.2 Abusive and Violent Patients

Both nurses and doctors complained about the amount of abuse and aggression they experience from their patients in their day-to-day professional work. This is especially true of the nursing staff. Some of the nurses interviewed believe this to be a gender issue in that the aggressive behaviour of female patients is significantly worse than male inmates. Women, apparently, in the custodial sense at least, are

worse than men. One explanation of why nurses are abused by women prisoners is that prisoners treat nurses as *de facto* correctional officers. But what ever the reason, gender is clearly an issue here.

> **Nurse 3, Minimum Security**: women are more aggressive than the men, and they are more abusive.
>
> **Nurse 4, Minimum Security**: I think that is a bit hard when you are trying to do things for the girls and you're helping them and they abuse you.

The nurses developed strategies for dealing with unreasonable behaviours and abusive patients. The nurses interviewed talked about the need for teamwork and the importance of debriefing. Having a supportive team with shared goals and commitments was thought to be very important in both managing abuse and maintaining staff morale.

> **Nurse 2, Minimum Security**: You can handle abusive inmates but it all depends on the staff you have. So if you have got a really supportive team, it is so much easier to deal with the girls than if you have got an awful team to work with and everyone is for themselves.

Other strategies deployed to defuse a potential or actual aggressive situation included using "time-out".

> **KW**: How do you deal with violence and aggression on a daily basis?
> **Nurse 1, Minimum Security**: We talk about strategies of how to deal with it. We close the window sometimes and just say "Look, we are just closing the window a moment and we will be back in 5 minutes" or we will say to someone "Look, we are not getting anywhere; how about you go away for 5 minutes and then come back". We are subjected to a lot of it and it is semi-accepted by the officers.

Certain situations were more likely to ignite the already short fuse of some of the inmates. As with children, the perception that they were being thwarted or not getting what they want when they wanted it was likely to anger some patients. In the context

of the clinic or at the 'pill window,' this usually meant not being unable to get a medical or dental appointment in what the patient considered a timely manner.

> **Nurse 3, Minimum Security**: They get very aggressive coming up to the window. "I want to see a doctor, I want to see the dentist" and you tell them "Well we have no appointments this week, come back on Monday, put your name down" and you cop the really foul language and the verbal abuse.

Custodial procedures affect the delivery of health care and elicit abusive and aggressive behaviour from some inmates. At the time of collecting data there was an incident in which one prisoner stabbed another. The gaol was locked down as a response. This impacted on the usual clinic practice.

> **KW**: After the stabbing you were saying there was a general lock down?
> **Nurse 1, Minimum Security**: yes
> **KW**: How does that make the girls feel?
> **Nurse 1, Minimum Security**: Oh very angry ... we did the methadone parade this morning and they were just being brought up one house at a time... which makes the methadone parade extremely long because we dose between 50 and 60 girls a day. Normally we do methadone and then sick parade from 9 am, but we were still doing methadone way past 9 o'clock and there were girls saying "I really need to see the nurse" and that is now happening at 10.30 and they were quite aggro about that.

Aggressive behaviour by inmates was made worse by the use of illicit drugs. Intoxicated patients, it was argued by some of the nurses, pose a threat to the safety of the gaol population as a whole as well as to the clinic staff. The extract below shows how one intoxicated patient behaved after being told she could not have her hormone replacement patch. A clinical decision was reached that the patient would only be provided with the patches as ordered. When the patient presented at the clinic window asking for another patch, which was not due for replacement for several days, she was refused by the attending nurse

> **Nurse 2, Minimum Security**: I think its amphetamines that they are getting in at the moment; there seems to be a drought on heroin. [The patient] was very bizarre, she came up for her patch and when told she could not have it. She became very aggressive to the nurse, and sat outside spewing. When the nurse

went over to operations this girl said was going to kill her. She actually came and stood in this nurse's space with officers in the compound witnessing this. She said "I am going to strangle you" and was very, very aggressive. The nurse was terrified, and horrified that the officers had done nothing about it. Later one said "Oh we thought you had the situation under control."

Stand-over tactics were not the only way patients intimidated health care staff. Several nurses and doctors spoke about patients abusing the system of complaint available to them. While recognising the real need for such systems of external oversight, this had been abused, and, as I reported in the previous chapter, to devastating effects for one nurse. According to some of the participants, threats of complaint to the Ombudsman were becoming more common.

Nurse 1, Minimum Security: the number of times that the girls will say too that they are going to contact the Ombudsman if you don't give them something that they want – that's the 'in' person at the moment…

Health care providers who participated in this research also spoke about inmate-on-inmate aggression. Health carers attempted to deal with this problem in a variety of ways. In the previous chapter I reported the case of a vulnerable Koori patient who was sexually assaulted and the health carer chose not report the incident to the custodial authorities. In other instances health care professionals do report occasions of aggression and violence by inmates to the prison authorities. In some cases, as in the one below, the health carer opted to assist vulnerable inmates by providing them with skills to make them less vulnerable and less of a target of abuse.

Doctor 3, Maximum Security: A lot of the girls try and get at each other and sometimes the girls aren't good at protecting themselves, particularly those in for the first time. They are very frightened of the other girls and they don't know how to cope - they are just targets. So I just explain to them how to cope in that situation and why the other girls are doing that, it's to get a reaction. I try to give them the skills on how to survive while they are in prison. But I don't interfere in that way, no.

The final example is not about patients who are abusive to others – either health care professionals or other inmates. It is about self destructive patients. The nurse recounting this story explains how difficult such patients can be and how many resources are required to care for these patients.

> **Nurse 3, Maximum Security**: [An inmate] came back from the court, and her behaviour is atrocious...She tried to strangle herself with a sock, so she's on camera, in the safe-suit. Her observations were perfect, her blood pressure was 120 over 80, and pupils were equal and reacting. She is development delayed... and she's foul, really foul. Two senior officers and I take her to the shower, no response. So I can't leave this girl who is not responding to the officers because it's 10 at night. I ring the doctor on call who knows [the inmate] who says get a laryngoscope. No body conscious can tolerate a laryngoscope down the throat so I stuffed the laryngoscope down the girl's neck, there wasn't a flicker. Not a flicker. Therefore we have to act. We have two emergency ambulances, we get the paramedics, she's cannulated, and her observations are perfect. And all this is going on. The officers meantime are having a panic state, because I had told them to take her to the shower... Yes you push it because on medical advice she was taken to the shower. She got to [the tertiary hospital], she got off the trolley and she walked to emergency.

6.2.3 Manipulative Patients

Health care professionals working in the correctional context must be vigilant for their personal safety. Violent and abusive patients, however, are not the only challenging patient behaviours. The health care professionals interviewed for this research raised the issue of having to be constantly aware of being manipulated by their patients. Complaining is a common form of manipulating the system. The HCCC received 32 complaints, against CHS during the year this research was undertaken.[10] Prisoners contacted the 'in' Ombudsman with 15 written complaints and 292 oral complaints against CHS in the same period.[11] Health care professionals, while recognising

[10] HCCC. *Annual Report 2003-4*, Government Publishing Services, Sydney, 2004. Available at http://www.hccc.nsw.gov.au/downloads/ar_03_04.pdf accessed 28.9.06

[11] NSW Ombudsman. *Annual Report 2002-3,* Government Publishing Services, Sydney, 2003. Available at http://www.ombo.nsw.gov.au/publication/PDF/annualreport/Ar03_02_Investigations.pdf accessed 28.9.06

prisoners have a valid right to complain, question the legitimacy of some of the complaints.

> **Doctor 1, Minimum Security**: There are lots of avenues which are right and good... inmates to complain about anything and everything to every official visitor who comes in with great regularity... Some of the girls complain non-stop about everything you do. So this type of ethics of inmates, I think it's good for them to have an avenue to complain because we're certainly not perfect and they need to have a voice, but some of the inmates who are used to surviving by manipulative situations and by lying and by trying to manoeuvre things in their favour do cause a lot of trouble.

6.2.4 Drugs in Prison

The use of drugs within prison is so problematic it warrants special attention. All the practitioners interviewed raised drug use and its attendant problems for clinical practice. The ongoing use of illicit drugs in correctional centres, according to the study participants, was more problematic in the minimum security facility. This is because security is less tight and the fact that some inmates work outside the prison or can visit the surrounding community prior to release. This is not to assert that practitioners at the maximum security correctional centre claimed no illicit drug use occurred there; it is just the situation is worse in the minimum security facility.

> **Nurse 4, Minimum Security**: There is not supposed to be [any drugs] but there is. I think it is a big problem and it is the way the girls and the visitors are searched. The best way would probably be locked visits... its amazing what they get in here.
> **KW**: So does this occur all the time or mainly at weekends?
> **Nurse, Minimum Security**: Weekends... the girls can go out and wander between the main complex and [other areas], and some go out shopping at the Plaza and they can bring it in themselves. So it is not just the visits and people throwing things over the fence and dropping off. You know it is not monitored well.

The illegal use of drugs in prison raises one of the most problematic issues for health care professionals, particularly the nurses. Unlike clinicians who practise in institutions dedicated to the provision of health care, doctors and nurses in

correctional settings must consider, and some of the practitioners prioritise, security. Frequently these two ideals – security and health care – are in tension. This inherent tension can be an uncomfortable place for some health care practitioners. That this role tension is ethically problematic is evident in the way the following health care practitioner resolved a dilemma. The problem is whether to privilege security arrangements – and report drug use within the correctional facility – or to act in the patient's best interests.

> **Nurse 1, Maximum Security**: The dilemma is sometimes I see a girl and think she's on something. Do I report that to the officers or don't I? And you if I report it, it means that this girl gets target urine done, if that target urine comes out positive there are certain punishments such as a month of docked visits. Sometimes, I don't report it because you know that if you report it, they'll target urine and I'm stuck with a problem of this girl has no contact with her children and it becomes a mental health issue. So if you report, they're punished, can't see their kids, and then they're depressed about it, and then we're stuck with it.

Some health care practitioners make a judgment about whether to report an intoxicated patient based on the type of drug used. In the following example the health care practitioner explains that Rohypnol use will be reported to the custodial authorities because the patient is at risk. This risk establishes a duty of care to the patient and to other inmates who may be put at risk by their aggressive behaviour. Interestingly, and pragmatically, this clinician does not fear retribution for reporting the intoxication, chiefly because of the amnesic effects of the drug.

> **Nurse 2, Maximum Security**: It's a dilemma when I see a girl who is intoxicated and there are certain signs that you can tell whether they are on benzos or not, or heroin. Certain symptoms you can look at and say it is definitely heroin. The officer asks if "Has she taken anything? And you think do I tell them that or don't I? Sometimes I have and sometimes I haven't, it depends on if I think others are at risk… If a girl reports to me that she's taken Rohypnol, because they become really off their face and can get very aggressive, I always report that to the officers because she's at risk, the other inmates are at risk, and the officers are at risk. So if she reports that to me, I'll definitely say it. And usually she won't remember the next day.

Conversely, some practitioners have no problem reporting intoxication. They have no problem reconciling their security role.

> **Nurse 4, Minimum Security:** If somebody turns up and they are intoxicated, I say look I am going to have to write out a health problem notification and the officers are going to check on you a couple of times tonight for your safety. So try not to be annoyed with it they are doing it to make sure your OK. So I have a pretty clear statement that I give them and I don't get troubled or angst over writing out documentation that this person is intoxicated. They are then target urined the next morning. "The bloody clinic put me in", they say and you know sometimes I say to them, "Look blind Harry could have seen that you were out of it." If they want to think that we have put them in, yeah but blind Harry could have seen.

Correctional health care clinicians, clearly, must be concerned with security issues. This will include protecting themselves, other health care and correctional staff, and their patients. How involved health care practitioners ought to be in security concerns is contentious and ethically problematic. While CHS staff must be mindful of the need for security and act in responsible ways with respect to security arrangements, they must also be mindful that their role is to provide health care. The blurring of the lines between the two connected, but distinct roles, may lead to dual loyalties.

Respondents also raised the issue of the use of prescription drugs for different purposes. Apart from not being able to prescribe drugs which could be used to make a weapon (eg. some drugs for treating angina), health care professionals must also be mindful of how the inmates might use prescription drugs for more creative and different purposes. Temazepam is a good example. Inmates were removing the liquid contents of this common sleeping tablet and injecting it intravenously - with dire consequences. Clinicians spoke about how quite commonly prescribed medications are used by inmates.

> **Nurse 3, Minimum Security**: They are very clever these girls, when you learn what they can do with drugs. I mean, they are really quite smart! They were

smoking Buscopan so that was withdrawn. Brufin, the 400mg pink pack pills or tablets; they can smoke those. Indocid [suppositories] that you take with antibiotics, they put them in foil and burn them and inhale them.
KW: What are the effects of doing these sorts of things?
Nurse 3, Minimum Security: Apparently, Buscopan was very bad, one girl tried to eat it, I heard about Demazin, and if you saw the number of girls that come up for Demazin, it is just staggering... It is very creative isn't it? And now they come up for Dexsal, for a tummy ache, we give them Dexsal now [only] if they take it in front of us, because they are using it as part of the brew, and the same what's the other thing - Ural, Ural sachets. A girl came up the other day and she said "I am having trouble weeing" and I said "Oh can you do a specimen?", and she said "No", I said "Can you do a specimen and I will test it and I'll see if you've got an infection?" "I just told you I can't do it." I said "Well I can't treat what I can't test." So then I copped the foul language and off she went and I never heard anymore about that.

Treating intoxicated patients is problematic. Patients who overdose must be sent out to the local tertiary hospital for emergency treatment as it cannot be provided on site at the correctional facilities. This fairly routine practice is problematic in the prison context. Intoxicated patients are bounced from one facility to the other – from prison to hospital and back again. The central reason for this is that prisoner patients are 'different' and some hospital staff do not like taking the time to care for them.

Nurse 2, Maximum Security: We've had girls sent to hospital intoxicated, go in by car with an officer, come back by ambulance and they are in a worse state than when I sent them in the first place. That has happened several times. The problem is the girls get Narcaned here, maybe here, maybe at the hospital. Narcan wears off and they send them back, needs another Narcan. So whenever we ring up the hospital and say we're sending such and such up, intoxicated, I've given her some Narcan [they say] "can't you keep them there?" [We say] "Well we can't do that because we're not a 24 hour facility". [They say] "We're just going to send them back anyway". And I've actually had that said to me by a doctor. So it's a real problem with the hospital ... they just see prisoners, aggression.

6.2.5 Patients as 'Time Wasters'

According to informants, prisoner patients waste doctors' and nurses' time in many different ways. The health care professionals interviewed find what they describe as time wasting as both frustrating and irritating. As already discussed, time wasters are

those who are not really sick, but want to get out of work with medical certificate, or those who demand drugs all the time. Time wasters are prisoners who attend the clinic for trivial health care matters, or just for something to do. According to the participants, they are prisoners who do not care about their health, but have their own 'agenda' or are only interested in 'scamming' the system. And finally, time wasters are those who are so hopeless, recalcitrant, or simply unable to be helped.

> **Nurse 3, Maximum Security**: Well, we're dealing with hopeless cases, a lot of hopeless cases, but they are taking up an awful lot of our time which should be spent on more productive things.

6.2.6 Patients as 'Revolving Doors'

Some of the health care professionals interviewed spoke patients of as revolving doors. Prisoner recidivism is an ongoing problem for the prisoners themselves, the community and DCS. Health care practitioners also find recidivism problematic for several reasons. Firstly, they work hard providing a standard of health care and improving the health of incarcerated women. But health and health care are not necessarily a priority for women after they are released. The reasons why many women are in prison in the first place, specifically a history of sexual followed by drug abuse is what they revert to when released. And the therapeutic interventions necessary to counteract or change these patterns are generally not available to patients in prisons.

> **Doctor 2, Maximum Security:** A lot of the women also have sexual abuse issues and a lot of them have started using substances from a very early age - 9, 10, 11, 12 years of age. Sometimes their parents have given them their first shot of heroin. The sexual abuse issues, they usually come up once they have withdrawn from substances and they are very vulnerable at that period. In a way though clinically it is good because they are open to ideas and self worth can be reinforced, staying off substances and so forth, and work through a little bit. I mean this is just bandaid interventions really because you can't really do that much but I try as much as I can to discuss different issues with them and to try and get them on the right path. When they go out again, though, a lot of

them just go back to substances because it's easier. They just blot out their problems and they usually re-offend and they come back.

There are some successes, however. A nurse notes that while recidivism is very high, some women do change their behaviours and do stay out of prison.

Nurse 2, Maximum Security: But I've seen remarkable changes in women that I've dealt with over a three year period, have gone out, come back in, recidivism is quite high, 66%, recidivism, huge. So we wonder why we call it corrections facility, it's a misnomer. But there is a natural history of drug use anyway. By the time they are 35 or 36 they've got to the end of the road and they want to change, so we don't have an older population here, vis-a-vis the age group. So yeah, people go back out and come back in, and they change over time.

6.2.7 'Them and Us'

The sometimes abusive, violent and manipulative clientele make it easy for relationships to be construed in terms of 'them and us'. The nursing staff interviewed, in particular, spoke about having to 'protect their backs', 'cover their butts', 'protect their registration,' 'having their jobs on the line'. The lack of power in the face of unrelenting prisoner abuse and a prisoner subculture of challenging authority are keenly felt by some of the nurses interviewed.

Nurse 2, Minimum Security: There was another woman who was starting to go [a nurse] and you think oh no! We don't want this to happen. I talked about how we understand them, we understand that they are not capable really, but when it gets to nasty episodes like this you want to not be a nurse, you want to be more powerful and more in charge and you want to have somebody say on the quiet "Leave her alone". And yet it is not nurse stuff you know. You want to be able to protect yourself.

A 'them and us' relationship is reinforced by what health care professionals see as prisoners having their own agenda. This agenda is in opposition, and antagonistic, to the health care professional's role and function.

6.2.8 'Winning and Losing'

The idea of 'winning and losing' is closely connected to 'them and us'. Patients win if they can manipulate the system to get what they want; they lose if the health care professionals prevent them from 'scamming'. Patients can win by wearing down staff and/or by playing health care professionals off against each other. In order to prevent or limit patients 'winning,' documentation and good communication was considered necessary.

> **Nurse 1, Minimum Security**: We document in their notes, and for somebody who is a difficult client and you see them at sick parade you have got the file there and you look at it. [A nurse] saw her yesterday and she was trying to scam this, and so from your notes you know this and, at the handover, pass information on. People do just work and work on us and sometimes they win and you just have to say, well they won that, they got that week's certificate off work.

Health care practitioners interviewed for this study maintain some patient's receive better health care while they are incarcerated than they would receive in the general community. Published research confirms this.[12] The health benefits of imprisonment, according to this research, apply to pregnant women and some women with a mental health illness. Imprisonment, however, can also exacerbate or even cause health problems. Patients with a severe mental illness and those with complex health problems do not have access to health care to an equivalent standard as the general community. Clinicians working in the prison context are simply unable to provide the community standard of health care to these patients for systemic reasons. For these patients, clinicians are unable to fulfil their ethical and professional obligations. This is also the case for patients who are made ill by being in prison.

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[12] See Butler et al. Mental disorder in the New South Wales prisoner population, *Australian and New Zealand Journal of Psychiatry,* 39, 2005, p.410 for patients with a mental health issue and Martin, SL. Kim, H. Kupper, LL. Meyer, RE. Hays, M. Is incarceration during pregnancy associated with infant birthweight? *American Journal of Public Health,* 87:9, 1997 for pregnant women who are incarcerated.

Specific ethical issues are raised by ethnicity and culture. Aboriginal and Torres Strait Islander people are over represented in the prison statistics. Providing culturally sensitive and appropriate care is rendered more difficult in the prison context, even though appropriate measures have been implemented to solve this problem.

Apart from complex clinical issues, clinicians must deal with their patients' tendency towards problematic behaviours, including abuse and violence, manipulation, illicit drug use, drug seeking practices, and recidivism. These, plus the lack of value prisoner patients accord health and health care lead some clinicians to characterise their relationships with, and to, patients in terms of 'them and us' and 'winning and losing'. Constructing the health care practitioner-patient relationship in oppositional terms – them versus us - is unusual in the health care context. In the prison context, patients are characterised as rational opponents rather than as partners working towards shared health goals. Thus, in the prison context, relationships become distorted.

The characterisation of patients as a rational opponent is an example of what is described in the literature as acculturation.[13] The requirement that clinicians report assaults on prisoners and illicit drug use is an example of dual loyalties. Mandatory reporting of assaults or drug use to authorities outside of the health care system is a clear example of a role conflict between ethical and professional duties to patients and custodial interests.

[13] Grant, A. Ethics and the role of the correctional officer, O'Toole, S. Eyland, S. (eds) *Corrections criminology,* Hawkins Press, Sydney, 2005.

6.3 *Other Occupations*

In this section I will discuss other groups that CHS clinicians regularly have contact with, including CHS administration, hospital clinicians, DCS administration, welfare staff, correctional officers and officers of the courts.

6.3.1 Corrections Health Services

In the correctional system, the practitioner-patient relationship does not exist in isolation, but in the context of a series of other relationships. Some of these relationships are *not* routine or usual for most other health care practitioners, for example with DCS administration and staff, courts and magistrates. Some of these relationships *are* routine and usual, for example with clinical colleagues, medical specialists, and hospital staff. The narratives of the research participants indicate that their relationships with both groups are distorted by context. Moreover, the practitioner-patient relationship is modified or subverted, in some cases, by these relationships. In this section I will discuss routine or usual relationships, followed by relationships deemed to be not usual for most health care practitioners.

6.3.1.1 The Relationship with CHS Staff

As with all institutions and workplaces, relationships between staff and between staff and the institutional administration are complex; this was reflected in the interview data. On the whole, the health care practitioners involved in this research worked satisfactorily with each other. The two professional groups – doctors and nurses –

worked together in a professional and collegial manner, and spoke well of each other. The doctors in particular regarded their medical and nursing colleagues highly.

> **Doctor 1, Maximum Security**: ... the support of the nursing staff has been great. I like working here because the people I work with are not only supremely competent and expert in what they do; they are quite a nice bunch of people to work with.

As is common to other contexts, nurses were very protective of doctors. Indeed, this was an unusual and defining feature of this relationship. Many of the doctors recognised this and stated that their work was made easier by protective nursing staff. The nurses' views on relationships with other CHS staff they work with were more ambivalent. Nurses recognised that the prison environment was an extremely challenging and often hostile one which involved relationships with demanding patients. This increased the importance of, and need for, support and team work. Most of the nurses interviewed at the minimum security facility spoke about the need for teamwork to manage the complex clinical and behavioural problems endemic in the patient population. They also recognised the importance of debriefing and supporting each other in order to cope with daily incidents of patient aggression and abuse. Even in the challenging prison context where nursing staff clearly recognise that they must 'stick together' the horizontal violence often reported as a feature of nursing is, unfortunately, evident. Chiarella[14] argues horizontal violence occurs in oppressed groups. It is violence against other members of the group. Horizontal violence in nursing, I suspect, occurs not only because nurses lack occupational power, but because of gender issues.

> **Nurse 1, Minimum Security**: How we relate to each other is really important. We have the personality disorders of the clients to cope with on a daily basis

[14] Chiarella, M. Values and pragmatics in nursing practice: where virtue creates its own difficulties, Jordens, C. Kerridge, I. Selgelid, M. (eds) *Policing Virtue?, Proceedings of the seventh annual seminar of the Centre for Values, Ethics and the Law in Medicine,* Sydney University Printing Press, Sydney, 2004, p.9.

and sort of violence nurses do to each other and that is about the hardest – it's coping with what we do to each other.

The lack of collegiality between nurses at the maximum security facility was evident. The experience of caring for patients in an environment where violence, coercion and manipulation were endemic and acculturation obvious influenced the relationships between nurses at this facility. All three nurses interviewed were critical of other nurses and, to a lesser extent, doctors. Two of the nurses interviewed were extremely critical of how acculturated their nursing colleagues were and of their judgmental and disrespectful attitudes towards patients. Talking about 'work' matters at lunch time is common to all occupations; but it was the *judgmental attitudes* expressed by nursing colleagues about patients at lunch time which bothered the nurse cited below.

Nurse 1, Maximum Security: I think the thing that bothers me most of all is that a lot of my [nursing] colleagues don't share my philosophy of what I believe is confidential. I don't think talking about Hepatitis C patients and HIV status at lunch is appropriate.

6.3.1.2 Corrections Health Administration

The practitioners interviewed had mixed views about the medical and nursing administrative staff in CHS. This ranged from stating that the administration was supportive and highly professional to very unsupportive and divorced from the reality of working at the prison coal face. But in the main, respondents thought highly of CHS administration, particularly of those who held senior administrative positions.

There were specific issues with CHS administration which elicited criticism by some practitioners. The cases of the nurse being persecuted by a prisoner and the nurse who breached confidentiality to the ambulance officer have already been discussed. The more general criticisms – being out of touch, not being sufficiently supportive,

and lack of resources – reflected the inherent tensions in the work, their physical isolation from peers, and because very few health care practitioners outside the prison context have any real understanding about the difficulty of the work. The perceived lack of support rendered clinicians less able to care for and cope with their patients.

6.3.2 Hospital Staff and Specialists

One source of tension for health care practitioners working in the two women's prisons was the attitude of outside hospital staff towards prisoners. The most vexing reason for complaint was about making outside appointments. The attitudes of clinicians outside the prison context impacted on the delivery of health care within prison and, ultimately, on the clinician-patient relationship. According to some participants, hospital staff did not understand the enormity of the task of getting prisoners to a hospital. Moreover, hospital staff, particularly medical specialists, were not prepared to tolerate the rude behaviour of prisoners. But it was the unwillingness of hospital staff to care appropriately for prisoners that distressed some participants: that, and the judgmental attitudes that prisoners were subjected to.

6.3.3 Department of Corrective Services

There is an inevitable tension between the roles of CHS and DCS. While both departments are concerned with the wellbeing of inmates, prisons exist to protect society from wrong doers and to 'correct' inmates. Therefore security, both in terms of keeping prisoners isolated from society and depriving them of their liberty, are necessarily fundamental to the *raison d'être* of DCS. CHS, on the other hand, is not charged with protecting society, correcting behaviours, or the deprivation of liberty.

It is responsible for providing a standard of health care to prisoners which is equivalent to that of the general community. When these two aims conflict, tension is unavoidable. This is further complicated by the fact that health care, in the main and for obvious reasons, is delivered within prison. CHS staff, then, work in a DCS controlled environment. Moreover, health care concerns are most usually subverted to security concerns. This is not to assert that a good working relationship between the departments and those working in prisons is impossible, indeed all recognise that it is highly desirable for that to occur.

6.3.3.1 Department of Corrective Services Administration

The relationship between DCS administration and clinical staff was an important one. A good working relationship has positive implications for the delivery of health care in the prison context, a poor working relationship impacts negatively on the delivery of health care and the patient-practitioner relationship. The participants working at the minimum security prison seemed to have a better relationship with the DCS administration than those working at the maximum security facility. Interestingly, several of those interviewed thought the relationship between health workers and the prison administration depended on personalities rather than policies. Diplomacy appeared to be central to a good working relationship. If diplomacy failed matters could deteriorate.

> **Doctor 1, Minimum Security**: I think it depends on the key players to some extent. I think our present nursing unit manager and our present Governor are reasonably harmonious in the way they get, on but our previous Governor and our previous nursing manager there were real battles going on and I think it somewhat depends on the personal views and the personnel styles. But I don't think that is at a policy level. I think its more give and take by the individuals concerned how you resolve problems. Our present nursing unit manager is really excellent - if there's a problem, sure, she'll try and play it down to some extent and try and smooth it out rather than becoming a big battle - it becomes

> something that is workable rather than all-out war. Rather than getting confrontational with the Corrections staff, then things go very badly.

The tension between DCS and CHS was more obvious in the maximum security correctional centre. And this occurred for two reasons. The first was the management style of the administration which, for several of the health care professionals interviewed, was considered adversarial and high handed. The second problem related to the relationship between DCS administration and other DCS staff. According to participants, DCS officers had been on strike because their overtime had been cut back.[15] Strike action meant the gaol was 'locked down' and consequently patients could not attend the clinic. Thus, relationships between DCS and CHS, and relationships between DCS administration and other DCS employees, impacted profoundly on the ability of health care providers to deliver an appropriate standard of care. It also impacted on the practitioner-patient relationship in that prisoners took out their frustrations on the clinicians.

Because clinicians work in the prison context they have a security role. Policy requires them to report *inter alia* assaults and intoxication to the correctional authorities. This has implications in terms of dual loyalties and a practitioner's ethical and professional obligations to patients, especially for confidentiality and beneficence. The requirement to take on roles antithetical to clinical and professional obligations, moreover, subverts the practitioner-patient relationship.

[15] This was also a problem at the minimum security correctional facility.

6.3.3.2 Correctional Officers

The DCS employees who CHS clinical staff work most closely with are correctional officers. Officers are rostered to work in the health care clinics and are responsible for the security and safety of both prisoners and health care practitioners. The officers working in the clinics, particularly those in the maximum security facilities, can influence the proper functioning of the clinic, the work load, and the confidence of the health care practitioners. The views expressed about correctional officers rostered to the clinics were diverse and frequent. In the main, though, the practitioners working in both prisons were critical of the correctional officers, though the reasons for the criticisms differed. The nursing staff who work in the clinics and most closely with officers were more likely to be critical of them. The practitioners interviewed distinguished between 'good' and 'helpful' officers and those who were 'bad' and 'unhelpful'. The problems articulated by practitioners about correctional officers included their attitudes to patients, their handling of security, and the negative impact some officers have in the clinic. The following extract supports the idea of correctional officers being 'good' and 'helpful.'

> **KW**: Is there a good relationship between you in the clinic and the officers who are here for your safety?
> **Doctor 3, Minimum Security**: Oh yes I think so. I think, particularly at [minimum security correctional centre], we have never had any problems at all with that. They are always quite supportive at the clinic.

The nurse quoted below was profoundly grateful for, and respectful of, the work of the correctional officers. This nurse has worked very closely with the custodial staff and not only recognised the importance of their roles; the nurse understood how pivotal they were in educating new health care staff. Indeed, this nurse was the

exception in the study sample in terms of her description of, and close relationship to, the correctional officers.

> **Nurse 3, Maximum Security**: Over the years I have developed a good relationship with the officers. I remember when I first went there you learnt basically from the officers in those days... I do find the officers excellent. No problems.

The following excerpt was a more common one in depicting correctional officers as 'bad' and 'unhelpful'. Health care practitioners recognise the importance of having a good working relationship with correctional officers, not in the least because they can ensure the smooth running of the clinics.

> **Nurse 1, Maximum Security**: The doctor I was working with today, she said to me, "The women come into us in a different frame of mind if they haven't been set up and antagonised outside [by the officers]". And they are easily upset and easily go off, that's why they are in goal. Because they haven't learnt to deal with garbage and idiots and walk away from it. Besides which they can't. They are locked into a little cell or a little cage as they call it waiting for whoever, the doctor, or me or the dentist, to call them out and they are at the mercy of whatever they are being yelled at. It's horrendous. Absolutely horrendous like that and I don't think anybody - see custodial really don't ... a lot of custodial staff see no value in health care for these women. They say what the hell are you worrying about, they're only etc., etc., etc. so what.

Some of the clinicians interviewed spoke about the different values between correctional officers and themselves. The nurse in the above extract believes many correctional officers do not see the value in providing health care to prisoners. Another difference in values between clinicians and custodial officers relates to security. Some participants maintained correctional officers were inflexible about security requirements and allowed these to override good sense and compassion.

> **Doctor 1, Maximum**: [A pregnant inmate] went to the [hospital] labour ward with officers for supervision. The woman was handcuffed, and they did not release the handcuffs. She gave birth in handcuffs. There is no chance, no way a woman giving birth to a child would suddenly get up and tear out of the hospital. It was the most illogical sort of thing to do. She found it really traumatic.

The relatively more relaxed security arrangements at the minimum security correctional centre was problematic for one nursing practitioner. The nurse felt that security ought to be tighter, because after all, the women in the minimum security prison could be unpredictable and violent.

> **Nurse 4, Minimum Security**: I think officers should always be here with an inmate, cause you never, just because we are a minimum security gaol it doesn't mean *they are not going to do something to us* (emphasis added).

6.3.3.3 Other Department of Corrective Services Staff

The other groups employed by DCS mentioned by participants include probation and parole, psychology, drug and alcohol counsellors and the risk intervention team. There were several problems raised by participants with regard to these DCS workers, not the least being the lack of coordinated care between CHS and DCS. This finding mirrors the liaison problems noted by the Ombudsman discussed in Chapter 3.

The issue of confidentiality and reports to probation and parole was discussed in Chapter 5. The following discussion raises different issues: issues inherent in the relationship between practitioners and DCS staff. Doctors at both research sites were most likely to be critical of other DCS staff, especially the probation and parole officers. A typical criticism related to the tensions between the different aims of the two departments and their separate functions. Therefore, there was tension between clinicians' ethical obligations to their patients and probation and parole officers' protection and security roles. There was also criticism of probation and parole officers' unrealistic expectations of prisoners who are addicted to drugs. The following extract illustrates how the health care practitioner understands health broadly and holistically in contrast to narrow and limited concerns of probation and

parole staff. Furthermore, because practitioners in the prison context must write reports to outside authorities, in this case probation and parole, they must advocate for their patients in unusual ways and they must decide how and when to be selective with information.

> **Doctor 3, Minimum Security**: When parole ring up, the parole here, and are writing a report for someone and they want to know how they are going and are they compliant with their medication. And we can make very brief statements like "yes, they are compliant with their medication, yes, they pick up their medication". I was about to write a report for [a patient] and I knew she was taking amphetamines each weekend. But I had no medical reason to tell them anything more. Yes she is going reasonably well, I said. I think I got passed that dilemma, but it would be a dilemma for others. When they [probation and parole] ask very specifically for information or they get the girls to sign a form saying you can have access to my urine results or my file. And I have sometimes contacted the girls and said you don't want them to, and they say "Oh my urine's been fine" - no it isn't, you've forgotten. You've forgotten, remember 2 months ago and they go "Oh yeah". Sometimes I sort of point out [that they] don't always give information [to probation and parole]. We see them in a very medical sense. These girls use drugs all their life; they are not going to stop. Most of them are not going to stop and here are parole officers in their 20's writing out these reports going "Shouldn't get parole because has used cannabis here last week" and you just say "Oh snap out of it, really". Let the girl go home to look after her kids. Does keeping her here 3 months more over having a joint last weekend so relevant? So we keep a bit of information or we start being selective. That's where we don't have a standard, a code of conduct. I do think we start selecting information that we give out but it is under advocating for the client. This is the sort of clients they are.

The doctor in the following extract explains how subtle pressure is used to get information about patients by probation and parole officers. And again, the conflict between the clinician's advocacy roles is in tension with the parole officer's obligation to assess the risks of allowing parole for a particular prisoner.

> **Doctor 1, Maximum Security**: I am constantly prevailed upon to provide information about inmates, and often this is sought in a very subtle way. It may not be a request for a written report, but someone will ring up and hint for information and kind of - not coerce, but try to seduce you into trying to give bits of information. I mean I am constantly contacted by probation and parole officers and they are, on the one hand, trying to put you into the role of the patient's advocate, but at the same time, are asking you to breach confidentiality by telling then things they imply are going to be in the interests of the patient, but in fact, may not be used that way. In other words, things that you might say

to them that you think might be in the interests of that person being paroled may in fact be used in a way that actually obstructs their parole. Because we may tell them many things and they will quote you selectively.

In the following case a nurse at the minimum security correctional centre is faced with a difficult patient who self-harmed. This case is different from the cases described above in that it is not about releasing a prisoner, but about the best way to care for a patient. Moreover, it describes how conflict can occur between the different health goals of the various occupational groups. It is an instance of 'turf war'. Usually women who self-harm, and certainly those who do so repeatedly are transferred to the maximum security facility, because while the minimum security facility does have a safe cell, it is considered in the patient's best interests, and for clear security reasons, to be in a more secure correctional facility. The nurse describes how she met with DCS staff over the best way to care for this patient. The clinic staff wanted the woman to be transferred to the appropriate and different correctional centre as did the correctional officers. However, the psychologists disagreed, and their view prevailed.

Nurse 3, Maximum Security: The agreement was that if she self-harmed, like she used to rip open her wounds, stuff soap up her vagina, there was all sorts of things, OK. It was horrible and we had a meeting with the Governor, and there was me and there was psychology and there was welfare. So we had this big meeting because they were considering whether to send her back [to the maximum security centre] because she had made several self-harm attempts, had written a suicide note and all this, and in the meeting they said "Well I think we should give her another 24 hours and let her do an agreement that she is not going to self-harm for 24 hours." I said therefore she's going to self-harm 24 hours later... I said you've given her a month, what's 24 hours going to do? She self harms all the time, she's clinging to a particular officer, who when they have days off she plays up the most. It was just stupid.

That was an issue that we actually discussed with Corrective Services, but the first time Corrective Services and Corrections Health were very much together in sending her back, it was the welfare psychologists who didn't want to. The officers didn't want her here; they couldn't watch her for 24 hours a day.

6.3.4 Courts and Magistrates

Writing reports for legal purposes pose ethical problems for some practitioners. This issue relates especially to psychiatrists. Psychiatrists, because they care for the some of the most vulnerable members of the community, are conscious of their role as patients' advocates. This is doubly so in prison: not only do psychiatrists have to care for extremely vulnerable patients, they must do so in the correctional context which is antithetical to the care of many of their mentally ill patients. There is tension, then, between the need to inform the courts of the patient's health status and progress and the doctor's advocacy role.

> **Doctor 3, Maximum Security**: In psychiatry, doing court reports is an ethical issue. I tell them [the patients] there are only certain occasions where the notes can be taken away from me and I have no say. If they are subpoenaed or if I am doing a court report I will use my notes.

A Warrant of Adjournment allows the prison authorities, on court orders, to hold a prisoner in custody until their return to the court. According to one participant, the court will also order a report(s): for example drug and alcohol, psychological and/or psychiatric. These reports prove ethically and professionally problematic for practitioners for two reasons: whether patients consent to the content of the report; and whether there is a professional role conflict.

> **Doctor 1, Maximum Security**: It's done in a way that the psychiatrist is an underling of the Governor of the prison; they assume that, they just assume that I'm here at the direction of the Governor and that I will write reports as such. Now taking the view that rightly or wrongly ... that I will write the report to the court where the person consents for me to do so, in other words, I ask them, I say look here I've been asked to do this report, I'm happy to provide a report for the court but I will need to know whether you consent to this, for me to do so.

6.4 Summary

The discussion of the social context raises ethical and professional issues for health care practitioners in a variety of important ways. Central ethical and professional concerns include the inability of practitioners to provide appropriate access to health care to a standard equivalent to the general community for many of their patients. The issue of acculturation is also of central importance here. There is evidence that some health care professionals assume custodial values and prioritise these over health care values. This best explains the description of patients as time wasters and concerns by participants over the way patients are treated by some health care practitioners working for CHS. More importantly, however, is the issue of dual loyalties: health care professionals are required to adopt a security role which is irreconcilable with their ethical and professional obligations to patients. This leads to a distortion of the practitioner-patient relationship. The construction of relationships between patients and health care professionals as adversarial and antagonistic is in part a result of this dual function.

The antagonistic and adversarial relationship between health care professionals and patients is also a result of what patients bring with them to prison. The context which brings together people with profound social problems and poor social skills, whose priorities do not include their health or health care, inexorably leads to difficult relationships between health care providers and their patients.

Other relationships feature in the provision of health care in the prison context. There are the usual relationships common to all health care professionals who work in other, more routine contexts. However, the relationships with clinical colleagues outside the

prison context are unusually difficult because of a lack of common understanding of the problems faced by clinicians working in prisons and because of the way prisoners are treated in these facilities. Prisoners are not welcome as patients. Consequently, health care professionals working in prisons feel isolated from their colleagues and frustrated by their treatment of prisoners.

The tension between the custodial values and concerns and health care values and concerns influences relationships with DCS administration and its staff and, ultimately, impacts on the practitioner-patient relationship. The mere fact of practising health care within a DCS controlled environment in which custodial concerns are privileged and in which health care practitioners must provide information to authorities outside the health care context demonstrates how different practising health care in prisons is to other, more usual contexts.

The tension between DCS and CHS also shows the relevance of Goffman's and Foucault's work on prisons. Surveillance is necessary to fulfil the purpose of the institution, and this is the main function or activity of the custodial staff. They are required to supervise and control the inmates. The gaze focuses on prison life. CHS staff, however, recognise the impact of the outside life on prisoners and the ongoing issues this raises for them. In the next chapter I discuss results on themes related to security and the organisational context.

Chapter Seven: Security and the Organisational Context

7.0 Synopsis

This chapter discusses CHS and DCS administrative and institutional policies, practices and procedures which impact on, influence, or shape the delivery of health care in prisons. The two central themes relating to the organisational context that will be discussed in this chapter are:

1. security, and safety;

2. policies, procedures and documentation.

Security is the overriding value in the prison context, so it shapes the organisational context. But security encompasses a variety of concerns. Thus in order to understand the effects of organisational context, it is important to unpack the various security concerns that arise in prisons, show what policies they give rise to, and reveal how those policies impact on health care and the ethics of delivering health care. It must be noted that security and protection are not the only custodial issues which impact on health care and its delivery. The main purpose of the prison system is to radically deprive inmates of their liberty. The ideology, policy, and practice of state-sanctioned coercion give rise to the security and protective functions of the correctional institutions.

7.1 Security, Safety, and Protection

Security concerns cover a range of issues, including security in terms of detaining prisoners and the personnel required to achieve this aim, and security in terms of protecting society from wrongdoers. Various policies, procedures and methods are implemented to achieve these aims: these include physical barriers such as the use of perimeter walls and control of entry and exit points; organisational policies of which the security classification of prisoners is an instance; politically driven policies such as getting tough on crime and legislation, for example, truth in sentencing laws. Organisational and political practices and policies, both formal and informal, impact on the delivery of health care to prisoners and on health care practitioners charged with caring for incarcerated patients. Moreover, these security practices and policies have ethical implications.

Security concerns arise in other, more personal ways. Concern about personal security was evident in the data, with 12 of the 13 health care professionals interviewed raising this issue. This finding is consistent with previous studies. Weiskopf[1] found that nurses working in the correctional context must remain vigilant at all times and, consequently, personal security concerns were an inherent and integral part of their practice. In my study, health care professionals were not only worried about their own security and safety; the security and safety of their patients, other health care workers and DCS staff were also of concern.

According to informants one of the most important issues about the various security concerns was that they interfered with the delivery and provision of health care to

[1] For example see Weiskopf, CS. Nurses' experience of caring for inmate patients *Journal of Advanced Nursing,* 49:4, 2005, pp.336-343.

inmates. Security concerns and organisational polices relating to security effectively made accessing health care both within and without the correctional complex problematic.

7.1.1 Blocked Access

One central theme which 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 can be blocked by physical barriers[2] - 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 or
> **KW**: Why?
> **Nurse 2, Minimum Security**: It can be a punishment for the girls, I've seen like officers not doing certain things for certain nurses that they don't get along with.

Political policies which have been given expression in legislation (eg. truth in sentencing) have led to overcrowding in prisons. Unfortunately, the increase in the prison population has not led to a concomitant increase in staff. Too many patients

[2] This will be discussed in the next chapter.

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**: Yes and we have 100 more women than we should have, and no extra staff. No more officers, no nurses, no more welfare people. 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 ones that block patients' access to health care. The health care practitioners use informal practices to block patients' access to health care. 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 to cope with too many prisoners at the pill window. It is also a strategy used when the clinics are understaffed.

> **Nurse 3, Minimum Security**: I was here alone in the sick parade, and I went out there and there were still heaps and heaps of girls to see, the phone was ringing, a lady from [the maximum security facility] was doing filing and she said to me "Oh there are visitors over in the compound want to be shown around the clinic." I had welfare on the phone saying "I've got this girl that's come over here, she really needs to see you NOW" and all this parade, and I said to the officer "The sick parade's finished, these girls names weren't down the last time I looked", "Oh no, no, no", he will put them down so they don't harass him at the window and way after the deadline. I mean if it is urgent obviously you see them, most of these just wanted certificates so they don't have to go work.

Accessing outside health care facilities for their patients proved particularly problematic for health care practitioners. It was problematic precisely because of DCS policy and security procedures. Correctional authorities prefer to minimise prisoner escorts as a security measure.[3] As already reported, only two prisoners per day can be escorted to hospital or specialist care by DCS correctional officers.

[3] Woodham, R. Security in correctional systems, O'Toole, S. Eyland, S. *Corrections Criminology,* Hawkins Press, Marrickville, 2005, p.56.

Doctor 1, Minimum Security: You want some X-ray, or a specialist appointment, or an ultrasound or something; you can only send two women in the one day.

Doctor 3, Minimum Security: So they might be waiting twelve months to get in to see a specialist about something and on the day of the appointment they find that after waiting twelve months to get in to see a specialist, there are a couple of emergency cases in the gaol and their appointment gets cancelled, because the emergency is wanting to go out. So they've got to wait another twelve 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 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 is an ongoing problem for doctors.

Doctor 1, Maximum Security: I can't get them out usually 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 6 beds. At any one time we had 15 or so women suffering from clearly psychotic illness, continuing psychotic illness. Increase that to twelve 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 goal. I think it's a travesty that they are in a gaol.

Lack of assess to appropriate treatment was not confined to forensic beds, it relates 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 interviewed related to the supply of clean needles and syringes. This issue was discussed in more detail in Chapter 5.

Nurse 2, Maximum Security: The fact that we don't offer a needle exchange program in this gaol... Now on the outside, any intravenous drug user has access to new needles and syringes - they certainly do not in gaol, 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-born disease. It's a huge ethical issue.

The education referred to in the above quotation is the 2 x 2 x 2 method of cleaning. Prisoners are instructed to wash any syringes and needles twice with cold water, twice with bleach and then again with cold water. According to some of the participants interviewed the practice of DCS providing bleach to inmates was fraught. Several participants told me that the practice of providing Milton tablets (bleach) had been withdrawn.

Nurse 4, Minimum Security: We used to actually give out Milton tablets to the girls [but] that's been withdrawn. Because [DCS] said you don't know how much [inmates] were mixing it, it gives them a false impression of sterilisation, that kind of stuff. But I figure some sterilisation is better than none. I had a problem with withdrawing the Milton. That's why, because we were actually giving them out to the girls and so they could sterilise their needles, but that wasn't put in writing. If they came in and asked for Milton, yep, sure here. I would not ask [why they wanted it] because if I asked they would not ask me for the Milton.

There was confusion over whether Milton tablets were provided. One nurse who worked in the same facility as the nurse cited above maintained that bleach was

available to inmates, but the correctional officers prohibited its distribution. Again, informal practices work to limit prisoners' access to health related care.

> **Nurse 1, Minimum Security**: Yeah, there's bleach, all the inmates have access to, but then I've heard of officers that say "No we have none". It's a policy that all the prisoners are to have bleach, but the officers will deny them, so and no one knows about it because everyone thinks that oh they have access to it.

Health care practitioners must be accompanied by correctional officers if they have 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.

7.1.2 Inside and Outside

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. The ethical principle underlying this issue is justice. It must be emphasised that incarceration is aimed at depriving prisoners of their liberty, it is not intended to deprive them of other rights.

Providing care outside, however, proved difficult for political reasons: inmates lost access to their Medicare entitlements. Consequently, patients and their clinicians were restricted in their ability to access health care outside the public hospital system. Being inside then, limits the health care available to prisoner patients, and, moreover, is construed by some health care professionals interviewed as a denial of human rights.

Doctor 2, Minimum Security: They are not covered by Medicare, so when you send them out into the community, and when you come into gaol you lose all your rights. And because - the government costing, 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 contrasted their practice inside the prison walls to their outside practice. In some cases, practitioners thought the care similar. In the following extract a doctor at the minimum security correctional centre explains that attitudes to people with a drug addiction were similar inside and outside. This was not seen as a good thing as these attitudes were judgmental and inappropriate.

Doctor 1, Minimum Security: I worked with drug and alcohol on the outside of the gaol system as well, and a lot of the clients who have drug problems, even if pretty much on top of the drug problems, are still seen as junkies or whatever, they're not - although I worked on the methadone program outside the gaol, the way, a lot of the clients are, you know, they might be married with children and mortgages and jobs, functioning well in society, and yet because they're on methadone, they're seen on a different level, and that's what I have problems with. So, ethics is respect for fellow human beings I think is the issue. And that is so on the outside of the goal as well and with a lot of the clients we have here.

Some health care professionals interviewed maintained prisoners received a different and worse standard of care inside prison than the standard of care which was 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 would.

One specific instance involved an American prisoner who was to be deported. This woman had been convicted smuggling drugs into Australia and she was to be

repatriated to an American prison. The woman had significant cardiac problems and her case raised several issues about better or worse health care inside prison. One issue related to the provision of care within the prison; another access to outside health care; and the third whether health care ought to be subsumed under politics. In the case below the health care practitioner could not provide adequate investigative services within prison, nor could she get timely access to specialist services outside prison. It also shows how specific political policies (extradition treaties) relating to prisoners impact on clinicians. The outcome, expatriation back to America, was difficult for the practitioner.

> **Doctor 1, Minimum Security**: There was a woman a couple of years ago now, who was an American who had a long [prison] sentence and she had significant pain, coronary artery disease and peripheral vascular disease. And she was one of the ones who always complained about everything you did - and whatever she had was never enough. And that worked against her. Because we can't get access to specialists, the other doctor and I often had to do our own investigating because couldn't get access to specialists. So this woman was worked up by us, it was so hard to do, but we did it in the end. She had significant coronary disease and when we ended getting to her to see a surgeon he refused to treat the patient, point blank, that was that. We had the Immigration Department involved at that stage because she was trying to get Immigration to say on medical grounds she wasn't fit to travel in a plane to America, so she wouldn't be deported. She had angiograms which showed it, and the surgeons wouldn't treat her, she had genuine medical needs and yet the vascular surgeon wouldn't treat her, so that was... She ended up getting deported but it was not a good outcome. They wouldn't treat her over here because she didn't have any health cover, so we were sending her to a country where she would have no health care, so she had less chance of getting health care there. I was not pleased with the outcome.

Apart from access issues, ensuring community equivalence proved problematic for practitioners. According to the practitioners interviewed, some categories of incarcerated patients receive worse care. As I indicated in the previous chapter, this includes women with psychiatric problems, particularly suffering from psychosis, and those with complex medical problems requiring sophisticated investigative or diagnostic biotechnology.

As discussed in the previous chapter, some groups of prisoners receive better access to some types of health care than they do outside prison. Women with a history of drug abuse and self-abuse, according to some of the interview participants, also receive better health care and treatment while they are incarcerated. In the correctional context these women are sent through detoxification and, if necessary, put on a methadone programme. Drug related health care problems are also treated in prison.

The lack of health care resources and appropriate hospital accommodation within prisons creates ethical issues for some participants. This problem is well known to both CHS and DCS and funding has been made available for improved facilities. At the time of interviews, however, the facilities, particularly at the maximum security facility, were suboptimal (see Chapter 8). The general lack of material resources and subsequent strain on human resources was commented on by both the nurses and doctors interviewed.

> **Doctor 2, Maximum Security**: the gaol system medically is overloaded ... the system is overloaded and under-sourced.

The problem of too many prisoners and too few staff was evident even in those clinical specialities in which patients are generally recognised as receiving better care than they would seek, and therefore get treatment for, outside prison. However, the sheer number of patients frequently means health care practitioners are unable to provide care adequately 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 division of health care between the two services (CHS and DCS) which involves two sets of confidential patient records was seen as a problem specific to this context. In other words, it does not occur 'outside' the prison context. For other practitioners, their inability to provide test results in a timely manner or to have appropriate follow-up was seen as an 'inside' problem. The reasons why clinicians are unable to follow-up care to patients include: prisoners are moved to a different gaol; prisoners are released; correctional officers don't inform the women that they have a medical appointment.

> **Nurse 1, Maximum Security**: I don't get to follow up girls to give results or to treat when results come. I worry about that.

As previously discussed, women prisoners found it especially difficult to cope with their remorse and concern about their family who were on the outside. These worries inevitably cause health care problems ranging from insomnia to anxiety. Moreover, because these women are inside they feel unable to control or greatly influence situations affecting their families. This can create a problem inside the gaol for the nursing staff in particular.

> **Nurse 2, Maximum Security**: Recently, last week, I had a positive Hep B (Hepatitis B). This is highly infectious, and we had to do a contact tracing. This very young girl had a four 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 to convince her that it wouldn't jeopardise her rights to that child, but there was a custody battle on with her *de facto* and the child was in care and I must have spent hours with this girl, with this 19-year-old young mother crying her eyes out, first time in gaol, having had a baby taken off her because she's a drug user.

7.1.3 Discipline and Order

Security issues are not generally a feature of medical or nursing education in Australia. Therefore staff employed by CHS must undergo security awareness courses. As I have already mentioned, concerns and issues about security were raised by the majority of participants at both research sites. At the minimum security correctional institution, lack of security and discipline was an issue.

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

The unpredictability of patients was also seen as an issue of personal security. Usually, relationships between professionals and patients are predicated on respect and trust. In the correctional context, however, being able to trust that your patients are well disposed towards you, or even benign, is foolish at best, dangerous at worst. Trust then is compromised when personal security is threatened.

> **Nurse 1, Minimum Security**: Yes, there are, I mean, um say 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, we don't always know 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 central to dealing with unpredictable and potentially violent inmates. Moreover, 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. Their job was to enforce discipline and preserve 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 of a 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 physical too... but I think they [correctional officers] need to be more of an authority figure (emphasis added).

The effect of lenient security and *laissez-faire* correctional officers, who, some of the nurses believed, did little to maintain discipline and authority over the abusive behaviour of inmates, was that many of the nurses interviewed did not feel safe at work.

Nurse 3, Minimum Security: the security is very bad from the officers, that I feel that they could do a lot more to make this place safer for the [health care] staff.

In the maximum security correctional facility concerns about personal security did not arise with reference to the lack of discipline and control of inmates by correctional officers, it was directly related to concern about working with violent and intractable patients. This issue was raised by both nurses and doctors working at this facility.

Nurse 2, Maximum Security: [this prison] is the most notorious prison in Australia. It is the highest maximum prison in this country, and some very scary people are housed in gaol.

The nurses at both institutions were 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. This is not an unusual practice; it is the case in most hospitals and health care clinics.

Nurse 2, Minimum Security: Keys, obviously, are the most important things to be aware of. Our drug keys always should be connected to a [nurse].

Unlike other health care settings, health care practitioners working in the correctional context have to be mindful of security including the security necessary for the detention of prisoners, and personal security (their security and the security of others). Personal security concerns included being careful about the conditions under which

patients may enter the clinic/hospital. Patients must not, under any circumstances, be given the keys to the clinic and, in fact, can only enter the clinic accompanied by a correctional officer. Health care professionals who ignore or override the policy and allow unaccompanied patients into the clinic do so based on their judgment and their knowledge of the criminal history of the patient. But knowing the crime may be a problem in itself. This issue is discussed in section 7.1.5.

> **Nurse 1, Minimum Security**: Never give the keys to inmates, they should never have access to your keys, in other words never give them the key to open up the door. Be aware of who you bring into the clinic, now 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, and on those occasions generally they're the clients I know their history, their crime history, basically, like 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.

Assessing the security risk of patients becomes a finely honed skill for practitioners working at CHS. They must use their clinical and moral judgment in making these assessments because their work environment is unpredictable and unsafe. In some cases, their personal security overrides 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 water, and in fact I would go so far as to say, and this sounds like I am judgmental, but believe me, I suppose I have maturity on my side that I 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).

Issues surrounding all meanings of security and policies to maintain security were explicitly or implicitly evident in all aspects of the provision of health care in prisons. The security classification of prisoners 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. This was important information for health care practitioners, for clinical reasons,

particularly for those concerned with the ante-natal care and mental health care of patients.

> **Doctor 2, Maximum Security**: When you are sentenced [prisoners] are given a classification ... depending on what their risk of escape would be... So they make a classification and this is important for me because I do ante-natal care for women, so if they are unsentenced 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.

Even providing seemingly innocuous information to patients had security implications. Outside appointment at hospitals or at hospital outpatient units were kept secret from patients because of security concerns.

> **Nurse 2, Minimum Security**: They [the patients] are not allowed to be told when they're going for appointments for security reasons.

7.1.4 Places of Control

Doyle argues that prisons are places of surveillance and control "[P]rison is a unique social system where inmates live, unwillingly and resentfully, in a highly structured and regulated environment. Privacy is nonexistent, surveillance is perpetual."[4]

So prisons are places of perpetual surveillance, they are places of control, within which prisoners are deprived of their liberty, and in which prisoners have no privacy. The lack of the inmates' personal liberty impacts on the provision of health care. Prisoners attempt to control their environment by the only means available to them, including manipulation and aggression. The nurses and doctors interviewed mentioned various strategies to cope with manipulation. One strategy was not giving in.

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[4] Doyle, J. A qualitative study of factors influencing psychiatric nursing practice in Australian prisons, *Perspectives in Psychiatric Care,* 35:1, 1999, p.31.

Not giving in also works when patients are being abusive and aggressive. One nurse related that she had just attended an Aggression Management Course. This provided the nurse with ways to enable her to have some control over her practice.

> **Nurse 3, Minimum Security**: I've actually changed my tactics from what I used to be like, now I never raise my voice, because then they raise their voice, and you get nowhere. I try to keep my tone down so that I don't sound angry, but it is difficult to keep that anger out of your voice sometimes. I changed my tactics; they would say "I want 7 Panadol" and I would say, "I'm sorry I'm not giving you 7 Panadol, I'm not allowed to give you that." Then they'd start screaming at me for their 7 Panadol. Now I say to them "I'm only giving you 6 Panadol" I repeat I'm only giving you 6 Panadol. So I've changed my tactics and I'm repeating what I've said before and I've found that the person in front of me tends to then walk away. If they get aggressive with you, try repeating what you've just said and after a while they just give up and think this person's hopeless - and I've found it worked.

7.1.5 Knowing the Crime

Knowing or not knowing the crime specifically related to security and safety and, for some, their ability to offer non-judgmental health care. It is an example of an informal policy. Whether health care practitioners ought to know the reason why their patients were incarcerated was an ethical issue for about half of those interviewed. Some of the reasons given by health care professionals for knowing the crime, predictably, were because this knowledge allowed them to minimise the risks to personal security. This was particularly true when dealing with very violent patients and those with a history of say, hostage taking. Practitioners also reported 'bending the rules' for prisoners whose imprisonment was for white collar crime; prisoners who did not threaten their personal security and safety, and who, perhaps belonged to a similar 'class'.

Even if practitioners had little interest in knowing the crime, they stated they found out about it anyway. There is no privacy in prisons, nor is any expected it seems. This has obvious ethical significance.

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

Not knowing the crime was considered important for providing non-judgmental and non-discriminatory care. The nurse in the following extract responds to a question of what ethical issues matter to her practice. Not knowing the crime is part of being able to treat all patients fairly.

> **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 CHS, I just to treat them as I would anyone else, fairly, all the same, you know, not to show any favouritism or discrimination towards them. I always bear in mind trying to do the best for the client, to meet their needs within limitations, but for the best outcome for the individual, irrespective.

Knowing or not knowing the crime is complicated, as the following case attests. The doctor cited below checks the criminal history of a new patient because the patient did not look or behave like a "prisoner". The doctor was deeply distressed on finding out the woman, who looked like someone they would meet outside of gaol, was incarcerated for a serious and terrible crime. This experience led the doctor to intentionally and purposefully not know the crime. The doctor points out, however, that it is virtually impossible not to know the crime of all prisoners, certainly for those involved in very high profile cases and reported in the media.

> **Doctor 2, Maximum Security**: When I was first working I had someone who came in and I thought she was another member of staff, she was obviously doing some kind of work in the office, very well presented, attractive, kind of well groomed woman and I think I was at that stage where I just thought she seemed so like someone that I would meet in my normal environment. It was a very good lesson in not being curious, because I actually looked back in her

notes found out she had killed her child, and this was when like my baby was about six months old, and I was devastated. But for a long time after that I didn't ever investigate what people were ... [in for].

7.1.6 Protection of other Patients

Security was also construed by the practitioners interviewed as the need to protect others. Moreover, security policies were in place which required health care practitioners to report assaults on prisoners. Apart from being required to report assaults, some health care practitioners interviewed considered reporting such incidents an ethical issue. In the following quotation the nurse has no problem reporting assaults because "it's a policy".

> **Nurse 2, Minimum Security**: We have talked about it the Governor and the deputy and they have mentioned it to their officers that if somebody has been assaulted this might be their first port of call, and they will make the statement that they don't want any one to know, but I say to them that I cannot keep this information. This is a *security issue* and we are bound, as *part of our job description* we must, it's a policy, its part of the policy and we must tell and notify the Governor that you have been assaulted. I have to fill out this form. I do not say you are assaulted, just that you are injured from an incident. I must notify someone so someone will be calling you up to talk to you about it. And they might say the clinic told the officers and they might make a noise and everything but to allow them to report an incident and to still remain innocent of having dobbed so they all have that knowledge that any assault any black eye will be notified. So I don't have a problem (emphasis added).

The following case is an example of the importance of the need to protect prisoners from other prisoners. A patient demonstrating bizarre behaviour reported experiencing fits. The staff at the time contacted the appropriate medical practitioner who, given the severity of the patient's condition, requested that she be moved into a house with other girls.

> **Nurse 1, Minimum Security**: She did have a mental illness, but her whole behaviour was strange, but it wasn't picked up... she was actually in a house on her own because of her behaviour, yet this girl presented with saying "I have been having fits," non-witnessed fits, and for her safety the girls 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" 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.

7.1.7 Protecting Patients from Themselves

The personal security of prisoners who self harm, as we have seen, is deeply problematic in the correctional context. The policy under which prisoners are prevented from harming themselves is the safe cell policy. The doctor primarily responsible for caring for women who self-harm maintained that this policy was therapeutically inappropriate (see Chapter 5 for more discussion).

Some of the nurses interviewed voiced a different perspective on patients who self-harm. It was the voice of frustration and irritation. If these patients were cared for in an institution whose purpose was to care and treat these patients appropriately, then some of the problems would be mitigated.

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

Research indicates the suicide rates are higher in the prison population than in the general community.

> [Fifty-four percent] of women ... had thought about suicide and 39% of women... had made an attempt. This compares with data from a national survey where 16% of respondents aged 17 and over had thought about suicide at some time in their life and 3.6% had made an attempt.[5]

[5] Butler, T. Milner, L. *2001 inmate health survey,* Corrections Health Services, Sydney, 2003, p.101

The reasons why the prisoner population is more likely to have suicidal ideation and to go on to attempt suicide are described below:

> [P]risoners have a lack of control over the future and fear of the unknown, they are isolated from their family, friends and social support networks, and they may be suffering from guilt and shame relating to their offending and incarceration. Imprisonment may become intolerable, with the lack of communicative resources, victimisation and intimidation from other inmates.[6]

Suicide attempts and deaths from suicide in a population which is highly regulated and monitored means DCS, under the responsibility of the Minister for Justice, has failed in its duty of care to prisoners. Consequently, practitioners reported that keeping this group of patients safe and secure was a priority. Thus both custodial and health care staff must be vigilant against suicide attempts. As one nurse succinctly puts it:

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

Protecting inmates from themselves can be a trying experience for the nurses and correctional officers. In the following example, the nurse and correctional officers are attempting to dress the patient in a restrictive, boiler suit.

> **Nurse 3, Maximum Security**: An inmate was ripping the greens off the other night ready to strangle herself again, and with six of the officers saying "Come on be a good girl, let us in to put the suit on you", and you get the usual carry on. I said for goodness sake, I've not got all the time in the world, just go in and put her in the suit and be done with it.

The nurse cited in the above extract demonstrates a very different attitude towards patients who self harm than the other clinicians interviewed at the maximum security facility. This is in stark contrast, for example, with the views of Doctor 1, Maximum Security. The nurse provides either an example of acculturation or 'going native' by

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[6] *Ibid.*

adopting custodial values and norms which have replaced health care values and norms or of "burn-out.

Clinicians are required to report suicide attempts and cases of self harm or 'slashing up' to the custodial authorities.

> **Nurse 4, Minimum Security**: When we were taking blood we she had scratched her arm, superficial laceration. She is normally a very high functioning girl but it's the coming down off her Methadone and she was tearful and so depressed and the last thing she wanted was DCS to know, but we said we would have to tell them and get together a meeting and see how we can help you out. It's awful when they are so depressed and down and you do make a bit of a show of them.

7.1.8 Protecting Themselves

Health care professionals must protect themselves from harm. This is achieved in various ways. Security awareness courses are undertaken by clinicians, for example. Clinicians also protected each other: doctors spoke about being protected by the nurses and in team meetings strategies were developed to manage dangerous patients. Clinicians also use informal policies to protect themselves: knowing the crime is one example, and making judgments about which patients can enter the clinic unaccompanied by a correctional officer is another.

The 'sight and sound' policy is the most obvious example of a policy designed to protect health care professionals. In some circumstances, clinicians think the policy is 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" that's of course with patients who are very ill and 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. I 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 refuse to comply with the policy as it breaches their presumptive ethical obligations. Most clinicians assess or judge the security threat and their judgment informs their decision to be within sight and sound, or just sight, of a correctional officer. It also informs their decision not to comply with the policy.

7.1.9 Medicine and Nursing to Achieve Different Aims

It is clear that because inmates are deprived of their liberty, security (detention) controls are required. Nurses and doctors working in this environment are required, as we have seen, to adopt a security role. In the stories told by the doctors and nurses who participated in this research, it was evident that the usual goals of health care are not only constrained by the prison context; they are challenged and reshaped by it. The evident prioritising of security concerns over health care is the clearest example of this. Doctors must be mindful about which drugs they prescribe not only because of the inventive ways these drugs might be consumed by their patients, but because some medications might be used to make incendiary devices.

Nurses and doctors must report to DCS any knowledge they have about illicit drugs entering the prison system. This issue is more relevant to the minimum security correctional centre and, according to the data, mainly affects nurses. However, it is a policy requirement for all health care professionals working in the prison context. This requirement raises questions about the purpose of nursing and medicine in the correctional context and moreover, raises questions about whether this role demands the subversion of clinical obligations.

One issue then, is whether to report specific patients to the custodial officers. A related but somewhat different issue is the question of whether knowledge about drug use on a larger scale ought to be reported to DCS administration. Reporting this issue to the Governor may be an appropriate one given that this information will impact not only on individual patients, but the whole gaol. Real risks to others ought to be reported for ethical reasons. My question is whether reporting this type of problem is a *nursing* role, particularly given nurses 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 there 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.

7.2 Summary

In this section I reported issues surrounding security, safety and protection, and supporting policies. Security can be understood in a variety of ways: security necessary to deprive persons of the liberty; the security and protection of society; the security of the gaol; the personal security of staff, and of individual prisoners. Security concerns give rise to policies. These include organisational policies such as safe cell, escort, sight and sound, and prohibitive policies which deny prisoners access to clean needles and syringes and political policies which find expression in law such as truth in sentencing. Some of these policies protect the gaol, some individual patients from harm while others protect CHS and DCS workers. Many of these policies, including policies which protect DCS and CHS staff from harm, adversely impact on the provision of health care in prisons. Moreover, these policies adversely

impact on the ethical and professional obligations of health care professionals working in correctional centres.

Health care practitioners, however, are further compromised professionally and ethically. Working in correctional centres requires them to attend to security concerns not usually found in more routine contexts, and, more importantly, adopt a security role. The obligation to perform security functions places health care practitioners in a position of dual loyalties which compromises their relationships with patients.

The data clearly show the complex and sometimes conflicting views about the various security requirements and the attendant policies and procedures that health care professionals are required to uphold. Some were ambivalent about this obligation; some wholeheartedly accept their security roles. Whatever the view, in the prison context, nursing and medicine were used to achieve different ends.

In the next chapter I will consider the physical context.

Chapter Eight: The physical context

8.0 Synopsis

The physical context refers to the prison itself – its designs and functions. Prisons are built specifically to contain, isolate, and observe those members of society requiring 'correction': "[T]he physical environment itself is one which is characterized by secure perimeters and the technology of surveillance and containment: omnipresent reminders of the restrictive and custodial nature of prison life".[1] In this chapter I will relate my experience of the physical context as well as the data specifically about how the physical characteristics of the prison impact on the provision of health care. Movement and places were the key issues relating to the physical context, these issues bear directly on the ethical requirement to deliver equivalent health care.

8.1 Experience of the Physical Context

Modern prisons are very different from those designed by Greenway during the time of Governor Macquarie. The architecture is no longer grand and inspirational; rather they are designed to secure and control prisoners. From my perspective, prisons are awesome and frightening places. The experience of entering a prison is forbidding and the razer wire, high fences, security checks and evident custodial presence makes it impossible to forget that you are in a prison: the physical reminders are too great and too imposing.

[1] Doyle, J. Custody and caring: innovations in Australian correctional mental health nursing practice in *Contemporary Nurse* 14, 2003, p.308.

The clinics are physically nested within the prisons. At the first visit to the maximum security correctional centre, after security checks, I was escorted to the clinic by a correctional officer. For the next three visits I was met by the health care staff being interviewed and they escorted me to the interview room. I was then escorted back to the visiting area at the conclusion of the interviews. At this time, the clinic and hospital annex needed refurbishment. It was indicated that upgrading the clinic was a high priority for CHS. Inmates would congregate around the pill window to request appointments or to receive medications, including methadone. On entering the clinic you are faced with the cells or, as the prisoners call them, the cages. Correctional officers are an obvious presence around the cells and outside the consultation rooms. The hospital annex is sparsely furnished and looked like a small and under-resourced hospital ward. Any attempts to improve the facilities have thus far failed because, according to the nursing staff, the amenities have been and will be destroyed by the inmates. The clinic had treatment/consultation rooms off to the sides. These contained the requisite utilitarian furniture. There was an administrative area with medical records and locked cupboards for storing drugs. At one of the clinic was the staff tea room. During my visits the clinic was noisy, frighteningly so, punctuated by loud swearing and the sounds of furniture being thrown about. The health care practitioners ignored the noise. Given the lack of space and the noise and for reasons of confidentiality, the interviews were conducted elsewhere.

The minimum security facility was less imposing than the maximum security facility. The setting was rural and one drove through cow paddocks to enter the prison. After security clearance checks I was allowed to enter the secure area and make my way to

the clinic. This was newer, neater and looked more like a modern health care clinic. The treatment and consulting rooms were better appointed. Parade times – sick, methadone – were noisy, sometimes brash, with inmates demanding attention and their medications. But the clinic was, on the whole, quieter and less fraught. There were no correctional officers obviously present in the corridors, just, on occasions, one reading a newspaper at the desk in the entrance hall. At the request of the participants, the interviews were all conducted on site at the clinic in a consultation room.

8.2 *Disciplinary Spaces*

Woodham argues that "[S]ecure custody and control of prisoners has always been the cornerstone of effective prison management."[2] The various and distinct disciplinary spaces – the compound, areas bounded by fences - and places within the correctional institutions were mentioned in the interviews. These places – cells, segregation, houses, pods, cages, and so on, were all mentioned with reference to the provision of health care:

> **Nurse 3, Maximum Security**: Now they have the whole of those cells where girls, who are withdrawing, when we've done the reception processes we medicate them, do a Health Notification form, and if they are well enough to go to [special unit], not likely to [have a] fit or anything they go down to [special unit], there are officers on duty all night, and they have the alarm. There are often three or four [prisoners] to a cell because we are short of beds, so there are often some beds and mattresses on the floor. And then we have the segro [segregation] section where girls are placed in segro for having abused somebody or done something else. And then we have safe cells at the back.

[2] Woodham, R. Security in correctional systems, O'Toole, S. Eyland, S. (eds) *Corrections Criminology,* Hawkins Press, Marrickville, 2005, p. 59.

Not only did the health care professionals interviewed talk about disciplinary spaces and places, they often use military metaphors for both correctional and health care practices. These practices occur in places – usually the clinic. For example patients can make medical appointments and see the nurses at the 'sick parade', they receive their prescribed methadone at the 'methadone parade', indigenous patients are seen at the AMS's 'parade' and prisoners attend 'muster'.

Cells are places to contain prisoners. Nurses and doctors do not have unlimited access to these spaces: they must be accompanied by several corrections officers, including one senior officer. Cells are not opened, as are doors, they are *cracked*.

> **Nurse 3, Maximum Security**: [DCS] have to get another officer in, in fact they have to get two officers in and permission to crack the cell at night, you can never crack the cell without permission. I've been there with having two and sometimes three officers there if it goes bad, and the senior officer always goes in first just in case.

8.3 Movement

Movement, particularly prisoner movement, was a feature of the discussions with the health care professionals interviewed. Prisoners were moved between parts of the prison, between their sleeping arrangements to work, to the clinic, to hospitals, and so on. This was an issue for health care professionals because movement in correctional centres is highly regulated and monitored. As too is the movement of health care professionals. Their movement in and around the prison complex, certainly in the maximum security prison, is constrained.

> **Nurse 4, Minimum Security**: I have never been to their rooms, but if you go into a cell you always have an officer... sometimes I will have more than one, I've never, its just part of the security awareness training, you don't go anywhere without an officer.

Regulation of movement, coming and going, also related to sending patients outside to hospital for treatment including specialist appointments. The movement of prisoners and their access to the clinic was also controlled. Sick parades, methadone clinics and medical appointments all involved the movement of prisoners in and around the prison, accompanied and supervised by correctional officers.

The movement of certain groups of inmates, for example, those in segregation was even more highly constrained. Officers needed to escort these prisoners to all other places in the prison, including the clinic. This meant the inmates have to move at a time convenient for the correctional officers.

Security, which was discussed in greater detail in the previous chapter, was maintained in part by controlling and regulating the movement of prisoners. Prisoner movement impacted on the provision of health care, but so too did the lack of prisoner movement. During lock downs, for example, prisoners are unable to move around the prison, including attending the clinic. In the overcrowded prison system, this is problematic for health care staff.

This lack of movement was also problematic when there were altogether too many prisoners in one place: too many prisoners congregating around the pill window; too many prisoners dawdling at sick parade; or too many prisoners standing around abusing the nursing staff. The health care practitioners interviewed expected the correctional officers to attend to this problem and disperse the group, but this did not always happen.

8.4 Being in Prison or 'It's a Gaol!'

Doyle,[3] in his study of mental health nurses working in an Australian correctional setting caring for both male and female prisoners, noted the subjects reported that:

> while some prisoners adapted reasonably well to the challenges and rigours of incarceration, others suffered tangibly. Most people, upon entering prison or remand, are thrust into a volatile, unpredictable environment where the risk of personal danger is omnipresent. For many offenders, this results in overwhelming feelings of anxiety, despair, hopelessness, personal disempowerment, and finality.

The results of my study support Doyle's findings. Participants in my study also report patients suffer depression related to incarceration.

> **Nurse 3, Minimum Security**: I would say they would be depressed. It's a gaol.

> **Nurse 1, Minimum Security**: Being incarcerated compounds the problem... it certainly is no ball for them in here.

The data support Foucault's thesis that prison disciplinary structures shape and give rise to new behaviours. Moreover, the data support Goffman's insights about the process of 'mortification'. When inmates are removed from all stable social arrangements and brutally stripped of their sense of self, anxiety, hopelessness and depression results.

8.5 Summary

The physical context is about security and control. While discussion of the physical context featured less in the discussions with the health care participants interviewed, some aspects of the physical context did impact on the provision of health care to prisoners. Control of space and the regulation of movement are central to the

[3] Doyle, J. *op cit.*

management of prisons, and these security arrangements interfere with clinicians' ability to provide health care to patients. Moreover, the physical environment of the prison is a constant reminder of the stark realities of prison life.

Thus far, I have discussed the ethical and professional values of the practitioners interviewed and the social, security and organisational and physical contexts of prisons. In the next chapter I will explore the issues raised by the data.

Chapter Nine: Discussion of results

9.0 Synopsis

The purpose of this work is to explore whether ethical aspects of health care delivery are challenged by the prison context and, if so, in what ways. Moreover, how do health care practitioners adapt their practice in response to these challenges? In this chapter a summary of the results outlined in the previous four chapters will be discussed as will the limitations of this study. Finally the results of this study will be compared with the existing literature on nurses and doctors working in the correctional context. On the basis of the evidence presented here, I will argue that there are inevitable tensions between health care and custodial roles and obligations, and despite or because of these tensions, dual loyalties remain problematic in the prison context. I will also argue that claims of exceptionalism are not borne out by the data. Rather, I will show that a principle based framework can provide not only a standard by which practice can be judged but also a framework that allows us to evaluate context. I will go on to argue that context matters in that it impacts profoundly on the ethical and professional obligations of health care practitioners to patients. Finally I will consider how this research can contribute to health care practice and the education of clinicians working in the prison context.

9.1 Summary of results

Context matters. The prison context, in which the radical deprivation of liberty underpins all organisational policies and practices and structures relationships, proved

problematic for health care practitioners in that they were, in the main, either unable to fulfil their ethical and professional obligations to patients or these obligations were profoundly compromised. Moreover, security requirements adopted by practitioners impacted in negative ways on practitioner-patient relationships.

In Chapter 5 clinicians' views on ethical virtues, values, principles and professional standards were discussed. While understanding their ethical and professional obligations, clinicians spoke about their inability to fulfil almost all of these duties to patients primarily because health care concerns were routinely subsumed or subverted to custodial concerns. Furthermore, custodial organisational behaviours and attitudes constrained professional autonomy evident in more usual health care contexts. Constrained professional autonomy and the inability to care properly for patients contributed to practitioners feeling both dissatisfied and frustrated.

These were not the only reasons for practitioners' feelings of frustration. The experience of caring for patients with complex physical and mental health problems, and difficult social problems which were expressed as violence and/or manipulation, were also sources of frustration and resignation. Some practitioners were ambivalent about their patients. On the one hand, they genuinely wanted the best for them and felt sympathy for their plight, on the other they felt fear and a sense of hopelessness brought about by trying to care for many patients who at best did not appreciate their efforts, at worst thwarted them.

The social context was discussed in Chapter 6; this included persons and groups that health care practitioners interact with on a regular basis such as patients and other employees of CHS and DCS.

Research indicates that women in prison suffer disproportionately from mental illness, developmental disabilities and health problems related to drug and alcohol abuse. These health issues pose particular problems for practitioners working in women's prisons. Caring for specific cultural and ethnic groups also creates challenges for practitioners, as do social issues specifically relating to *women* as prisoners. Moreover, inmates can experience health problems caused or exacerbated by incarceration. The guilt and subsequent depression experienced by many women inmates about their relationship with their children is an example of health problems caused or exacerbated by incarceration.

Clinicians' ability to care for patients with complex health problems was complicated by being in the prison context. While some groups of patients receive better health care while they are incarcerated, many patients, particularly those with complex health problems, do not receive care to the community equivalent standard. The patients' tendency towards problematic behaviours and attitudes also caused problems for health care practitioners and often compromised the practitioner-patient relationship. Trust is undermined when clinicians cannot be certain their patients will not harm them or when therapeutic goals are not shared.

Practitioners spoke about the inmates' lack of social and emotional skills and their destructive and abusive behaviour. This behaviour influences health care provision and the practitioner-patient relationship. Practitioner attitudes to patients indicated acculturation and dual loyalties were at issue. Descriptions of patients as 'time wasters', and attitudes of 'them and us' and 'winning and losing' show how

problematic some prisoner behaviours can be for health care professionals and provide insight into prison culture. These descriptions and attitudes towards prisoners may indicate evidence of acculturation taking precedence over professional norms.

Participants reported that routine relationships with CHS colleagues were mixed but generally positive. Participants overall felt supported by their colleagues and the administration. There were exceptions – some nurses felt let down by the ethical and professional standards of their nursing colleagues and some staff felt unsupported by CHS administration. Feeling unsupported is not unusual in the health care context: many clinicians feel neglected by nursing and medical administration. However, the situations in which practitioners working in the prison context experienced feeling unsupported differed from the usual ones. The relationships between CHS clinicians and clinicians outside the prison context were problematic. These relationships were distorted by context; rather than collegiality the experience was one of isolation and misunderstanding.

Relationships which were not routine or usual for health care practitioners included those with DCS staff and administration, and the courts. Despite evidence of dual loyalties, the data indicate there is an often tense relationship between health care professionals and DCS staff and administration. The inherent tension between the conflicting values of the two groups and the privileging of custodial concerns over health care concerns are the main causes of the conflict. Privileging security concerns over all others including health care concerns, and requiring health care practitioners to adopt a security role further distorted the practitioner-patient relationship.

Security and the organisational context were discussed in Chapter 7. The data showed that security is a complex issue and participants discussed a variety of security-related issues as well as a variety of meanings of security. Security concerns gave rise to formal and informal policies. The various types of security concerns and associated policies all had ethical and professional implications on and for health care practice and practitioners.

Imprisonment is the paradigmatic example of legitimate coercion. The secure detention of inmates is achieved by physical means (secure perimeters, control of entry and egress, cells and locks), political policies which are expressed in law (eg. truth in sentencing) and organisational policies. The organisational polices involved in detaining prisoners included the security classification of inmates, regulating transport in and out of the prison and controlling access to prisoners. Participants report all these arrangements impact on the provision of health care and raise practical as well as ethical and professional difficulties for them. Clear examples include: 'cracking' cells; increases in the number of prisoners; security classification of women with babies; and accessing health care outside the prison system to name a few.

Security concerns were also raised in the context of personal security including security of the health care professional, security of other health care workers, DCS staff and other prisoners. Given the prison population, personal security concerns and the policies which aim to keep staff safe are clearly important. But many of these policies raise conflicting to ethical and professional obligations and norms. Policies which aim to protect health care workers include the sight and sound policy and the

requirement that practitioners undergo security awareness courses. The sight and sound policy in particular has ethical implications in terms of confidentiality, privacy and beneficence. Policies which aim to protect DCS staff, particularly officers, such as not allowing a needle and syringe exchange programme in prison also have ethical implications in terms of access to health care and community equivalence. According to some practitioners responsible for the care of these women, protecting individual patients from themselves – safe cell practice – is therapeutically and ethically unconscionable.

The security of the prison as a whole requires health care practitioners to report *inter alia* assaults and intoxication of prisoners and to restrict access to certain drugs. The rationale for such policies is justified in terms of duty of care (nonmaleficence) and for utilitarian reasons such as the good of the prison community. It is not uncommon for doctors and nurses to report notifiable conditions for what they perceive to be both the individual and common good. Public health measures do precisely this; however in the prison context, practitioners are required to adopt a security role which extends far beyond the usual public health requirements. Requiring doctors and nurses to adopt these extended roles conflicts with their professional and ethical norms. This requirement is, moreover, detrimental to the practitioner-patient relationship, particularly in terms of trust.

In Chapter 8 the physical context was discussed. Control of space, entry and exit points and the regulation of movement are cental to the management of prisons. These security arrangements interfere with clinicians' ability to provide health care to patients. The physical environment of the prison is overwhelming and a constant reminder of the stark realities of prison life.

9.2 *Limitations of the Study*

This study has several limitations. The main limitation of this study, however, was that the methods rely almost entirely on self-reporting. Participants may censor what they report, and this was not verified by observations of their behaviour. A caveat to generalising the findings is that the interviews with the participants took place in women's prisons. Moreover, the study focussed on the experience of caring for women inmates in NSW, Australia. Other Australian states have different arrangements for providing health care to prisoners. The findings of this study, therefore, may not be readily generalisable to different models of providing health care to inmates in Australia or elsewhere. The study was also limited by interviewing health care professionals only.

However, while there are clear limitations to this study, I would argue the results are still important since the contexts and conditions encountered in this study would be the same or similar elsewhere. Moreover this study's findings accords with other published studies on the experience of health carers working in correctional contexts. While empirical research on doctors and especially nurses has been undertaken, little published research specifically on ethical and professional values exists. Therefore this research contributes to our understanding of the impact of context on nurses' and doctors' ethical and professional obligations. I would also argue that the findings of this research will be useful to practitioners and policy makers in NSW.

9.3 *Ethical and Professional Issues Raised in the Literature and the Study Results*

In this section, some important issues raised in the published literature will be discussed in the light of the results of this study. This discussion will be confined to issues related to ethical aspects of health care. The main issues covered in this section are dual loyalties, values tension, exceptionalism and theories relevant to the prison context.

Published research on the experience of health care professionals (mainly nurses) working in the prison context and in correctional and forensic health care texts raises several issues related to ethics and professional practice.[1] One issue reported in the literature and consistent with the findings of this study was that health care professionals were concerned about their personal safety.[2] The doctors and nurses not only spoke about their worries in caring for unpredictable and violent patients they related how these concerns impacted on their practice. In some cases the real concern about violent patients led practitioners to breach their ethical obligations to patients, usually in ways related to privacy and confidentiality.

The need for nurses to be vigilant about personal security was also reported in the literature.[3] My research also found that health care practitioners did need to be vigilant for reasons of personal security, but also for other reasons. The nurses interviewed spoke about the importance of keeping the drug keys safe and about conditions under which patients were able to access the clinics. Clinicians were also

[1] Crampton, R. How do nurses care for prisoner patients? Negative attitudes towards prisoner patients, and a range of moral and ethical conflicts, can make the caring role difficult for some nurses, *Kai Tiaki: Nursing New Zealand,* 13:3, 2007; Maeve, MK. Nursing practice with incarcerated women: caring with mandated isolation. *Issues in Mental Health Nursing,* 18, 1997.
[2] Weinstein, HC. Ethics in Security Hospitals, *Behavioural sciences and the Law,* 20, 2002.
[3] Weiskopf, CS. Nurses' experience of caring for inmate patients *Journal of Advanced Nursing,* 49:4, 2005.

vigilant about security concerns particularly relating to drug and alcohol abuse and self harm. These issues were less evident in the literature, but clearly important in this study.

Reports to third parties were raised in the literature and in this study.[4] Reporting to authorities outside the health care system about their patient's mental state, drug taking history and so on, was mainly the role of doctors and particularly psychiatrists. This practice posed ethical problems for them, especially in terms of their obligations to patients for autonomy, consent, beneficence, and confidentiality.

Isolation was another issue raised by previously published research and evident in this research.[5] Isolation was discussed in terms of physical isolation associated with working in prisons. Isolation was also an issue because clinicians feel isolated because professional colleagues outside of the prison context neither understood the specific issues clinicians face working with inmates and the custodial authorities, and also the impact of outside clinician's judgmental attitudes about, and poor treatment of, inmates. These all combined to leave clinicians working in the correctional context feeling isolated and frustrated.

Acculturation, in which health care practitioners assume custodial values and practices, was found to be significant in this research, and consistent with other empirical studies.[6] Acculturation was evident in the ways some health care

[4] Taborda, JGV. Arbleda-Flórez, J. Forensic Medicine in the next century: some ethical challenges, *International Journal of Offender Therapy and Comparative Criminology,* 43:2, 1999.

[5] Holmwood, C. Rae, D. Prison Health: a different place for GPs, *Australian Family Physician,* 32:10, 2003, and Doyle, J. Prisoners as patients: the experience of delivering mental health nursing care in an Australian prison, *Journal of Psychosocial Nursing and Mental Health Services,* 36:12, 1998.

[6] Grant, A. Ethics and the role of the correctional officer, O'Toole, S. Eyland, S. (eds) *Corrections criminology,* Hawkins Press, Sydney, 2005.

practitioners spoke about their patients – as time wasters, scammers, and so on – and in some of the health care practitioners' uncritical attitudes about correctional staff. The phenomenon was described to me as clinicians 'going native'.

One further issue which ought to be discussed briefly is that of core competencies.[7] The nurses surveyed stated that they were very capable of meeting their ethical requirement to patients. This finding was not consistent with this research.

The final issue to be discussed as it is raised in the literature on both nurses and doctors working in correctional contexts are that of killing for the state. This was not an issue in the NSW context, given capital punishment is no longer legally practised in Australia.

9.3.1 Values Tension

Values tension describes the tension and conflict between the goals of health care and those of security. Gadow[8] makes the strong claim that these goals are oppositional because custodial goals include punishment and harm, while health care goals include promoting patient well-being and beneficence. The authors cited in Chapter 2 argue that health care and custodial goals are incompatible.[9]

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[7] Cashin, A. Potter, E. *The core capabilities of Justice Health nurses*, NSW Justice Health, Sydney, 2007.

[8] Gadow, S. Restorative nursing: toward a philosophy of modern punishment, *Nursing Philosophy,* 4, 2003.

[9] Smith, S. Stepping through the looking glass: professional autonomy in correctional nursing, *Corrections Today,* 67:1, 2005, p.54. Weiskopf, CS. Nurses' experience of caring for inmate patients *Journal of Advanced Nursing,* 49:4, 2005. Willmott, Y. Prison nursing: the tension between custody and care, *British Journal of Nursing,* 6:6, 1997. Dale, C. Woods, P. *Caring for Prisoners,* Royal College of Nursing, London, 2001. Gulotta, K. Factors affecting nursing practice in a correctional health care setting, *Journal of Prison and Jail Health,* 6:1, 1986.

This research found the incompatibilities between health care and custodial goals and values did create tension. And, moreover, this tension was inevitable and necessary. Failure to find evidence of values tensions would have indicated a vast and unacceptable level of acculturation of custodial values and gaols and dual loyalties. This is not to assert that there was no evidence of acculturation and dual loyalties. I have already suggested that such evidence exists and would argue that it is ethically problematic. Acculturation did not appear to be endemic. The question of dual loyalties is more problematic and will be addressed more fully in the following sections.

An important finding of this research was that apart from the inevitable and necessary tension between the two groups, conflict was also evident. Conflict arose in situations whereby health care concerns were subordinated or subverted to custodial concerns and priorities. Conflicts of this sort were evident in discussions of safe cell practice, escort policies, sight and sound policies, the requirement to report intoxication and assault, the failure to provide sterile intravenous needles and syringes, to name a few.

9.3.2 Dual Loyalties

The literature on dual loyalties is at times unclear, confusing conflicts of obligations with dual loyalties. The two concepts need to be clearly distinguished. Dual loyalties are distinct from conflicting obligations. Conflicting obligations are a part of usual health care practice and evident in cases where concurrent obligations exist. As health care professionals have multiple relationships with patients and their families, as well as relationships with employers, colleagues, professional associations and so on, such manifold obligations will inevitably conflict. These may be resolved in

equitable ways or some person or party may be disadvantaged. Provided the resolution involves the least possible harm to persons or parties, no special ethical problem arises. These types of conflicts differ from dual loyalties in that dual loyalties always raise special moral problems in that the requirements of one relationship necessitates the abrogation of obligations to the other(s).[10]

Requiring health care practitioners to adopt a security and discipline role which overrides ethical and professional obligations are clear examples of dual loyalties. In other, more usual contexts, health care professionals are required to report to outside health authorities; for example, they must report cases of infectious diseases to the NSW Department of Health via the local Public Health Unit. This requirement is legislated under the *Public Health Act,* 1991.[11] Imprisonment, properly, does not alter these legislative requirements. However, the reporting required by health care workers' security role in the prison context goes beyond the usual requirements in law. Morally, health care professionals are not required to adopt a security role, nor are they required to report cases to non-health care authorities.

9.3.3 Exceptionalism

Exceptionalism is the idea that phenomena are exceptional or 'unique' and thus do not conform to usual norms or principles. In the health care context claims of exceptionalism have been applied to research ethics[12] and, more recently, genetics.[13]

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[10] Toulmin, S. Divided loyalties and ambiguous relationships, *Social Science and Medicine,* 23:8, 1986.
[11] Reynolds, C. *Public Health: law and regulation,* The Federation Press, Sydney, 2004, p.218.
[12] Lurie, P. Greco, DB. US exceptionalism comes to research ethics, *Lancet*, 365:9471, 2005.
[13] Rothstein, MA. Genetic exceptionalism and legislative pragmatism, *Hasting Center Report*, 35:4, 2005.

Various nursing and medical[14] authors argue that nursing and medicine in the correctional context is unique for several reasons: it is a strictly controlled environment; the patients are different; and because of the exceptional skills and knowledge required by the context. The idea that practising nursing or medicine in the prison context is especially different is not confined to the academic literature. Several research participants stated that the prison context was unique.

The exceptionalism claims in the literature and those made by the research participants need unpacking. Arguments for exceptionalism cannot depend merely on difference: after all, every health care context can claim to different, therefore claims of exceptionalism must depend on being 'unique'. One claim is that correctional nursing (and medicine) requires different clinical skills and knowledge to nursing (and medicine) in other, more usual contexts. My research found no evidence that different nursing or medical clinical skills and knowledge were essential for correctional health care. Nurses and doctors used the same or similar clinical knowledge and skills to perform the health care duties in prison as they would outside prison; for example in general practice in the inner city. What was different from other health care contexts was the knowledge essential to understanding and working in the correctional system. Specialised systemic knowledge will differ from context to context; however, knowledge about understanding specific systems is not special to the prison context.

[14] See for example Gulotta, K. Factors affecting nursing practice in a correctional health care setting, *Journal of Prison and Jail Health,* 6:1, 1986, and Lynch, V. Forensic aspects of health care: new roles, new responsibilities, *Journal of Psychosocial Nursing and Mental Health Services,* 31:11, 1993, for nursing and Levy, M. Prisoner's right to health and safety, Brown, DL. Wilkie, M. (eds) *Prisoners as citizens: human rights in Australian prisons*, The Federation Press, Sydney, 2002 for medicine.

Another argument for exceptionalism in correctional practice is that the patients are in some ways 'unique'. This research found no evidence that the patients were especially different in terms of their health care needs. Practitioners working in forensic units in mental health hospitals, and those working with patients addicted to illicit drugs, would experience the same or similar types of patients. It was clear however, that the prison context impacts on patients. Goffman's work clearly demonstrates this. However, while these patients are extreme cases of problematic patients, they are not 'unique'.

The prison environment is also cited as a reason to claim the unique status of prison health care.[15] I found evidence that context matters in that it subverts clinicians' ethical and professional obligations and distorts the practitioner-patient relationship. However, the context is not exceptional and has much in common with the provision of health care in detention centres and in the military context.[16] As Goffman[17] argues, total institutions share common characteristics to an intense degree. If prison health care is truly exceptional, it could be expected that it would raise 'unique' legal and ethical issues. This study specifically investigated ethical issues faced by clinicians working in women's prisons and found that, while context is important, it did not raise any 'unique' ethical issues.

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[15] Laffan, S. The 'inside look' on correctional nursing: a unique nursing speciality, *New Jersey Nurse*, 35:1, 2005.
[16] See Zion, D. Caring for detained asylum seekers, human rights and bioethics, *Australian and New Zealand Journal of Public Health*, 28:6, 2004 and Clark, PA. Medical Ethics at Guantanamo Bay and Abu Ghraib: the problem of dual loyalty, *The Journal of Law, Medicine and Ethics*, 34:3, 2006.
[17] Goffman, E. *Asylums, Essays on the social situation of mental patients and other inmates*, Anchor Books, New York, 1961.

9.3.4 Theories of the Prison Context

Goffman's,[18] and to a lesser extent, Foucault's[19] work have clear relevance to this research on the provision of health care in the prison context both in terms of the organisational structure and features of institutions and in terms of "making up" persons. These theories, however, are not without criticism: this research indicates that the extent to which persons are "made up" by the institutional context is under theorised.

First I will consider insights from Goffman's and Foucault's work which is consistent with my research, and then discuss findings which diverge from it. Goffman argues penal institutions function to protect society, thus the welfare of those imprisoned is *incidental* to the institution's primary purpose. The Inquiries discussed in Chapter 3, particularly the Nagle Report and the New South Wales Task Force, found prisoner welfare, specifically health care, was subordinated to security concerns. My research data supported this notion. Custodial surveillance and discipline concerns continually overrode health care and consequently subverted clinicians' ethical and professional obligations.

Goffman noted that total institutions were impermeable and rigid. The problems implementing change required by the Inquiries demonstrated this institutional resistance to change. In terms of my research, the clinicians interviewed raised issues which were strikingly similar to those raised by the Inquiries. These included security concerns overriding health care concerns, the tension between DCS and clinicians,

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[18] Goffman, E. *Asylums, Essays on the social situation of mental patients and other inmates*, Anchor Books, New York, 1961.
[19] Foucault, M. *Discipline and Punish: the birth of the prison*, Sheridan, A.M. (trans) Penguin, London, 1977.

lack of coordinated teamwork between DCS staff providing welfare services and CHS staff providing health care and problems with confidentiality at the 'pill' window to name a few.

Goffman's research showed how total institutions "made up" people. By depriving inmates of the basic social arrangements of modern life – family and work – and by strictly controlling and regulating their existence, institutionalised selves were transformed and 'mortified'. Self-determination, autonomy and freedom are impossible in total institutions. This has profound implications for health care professionals working in the prison context.

He also argued that total institutions justify their treatment of inmates on the grounds of security. This research too showed that security concerns subordinated all other concerns. The refusal to provide prisoners with clean needles and syringes is an example of this, as too is the requirement to report intoxication.

Goffman argues that the total institution's work is also people-work and therefore they must provide humane services. Health care fits under this description. Goffman notes however, that those responsible for providing humane services feel dissatisfied with their work. They feel dissatisfied because they are unable to fulfil their obligations to their patients/clients: or in Goffman's words, they are unable to practise their calling due to institutional constraints. My research is consistent with Goffman's conclusion.

Goffman's analysis is not specific enough, nor sufficiently fine-grained to account for differences between total institutions. Davies'[20] analysis of total institutions provides insight into differences between institutions, in this case differences between maximum and minimum correctional facilities. Davies analyses institutions in three ways: degree of openness, purpose, and ways of eliciting compliance from inmates.

Based on Davies' analysis of total institutions, differences between the maximum and minimum correctional centre emerge. While the hierarchy is rigid in both facilities, the minimum security facility is less closed. Inmates have limited access to the outside community for the purpose of work and recreation. Their purpose also differs: the maximum security facility functions to isolate prisoners from the outside and to transform them. Less emphasis is placed on isolation at the minimum security centre. The final criterion is how inmate compliance is achieved. In both cases inmate compliance is realised by coercion, but the minimum security complex is less coercive.

Davies' analysis of total institutions has implications for health care professionals working in the correctional context. Closed institutions will have greater levels of surveillance, regulation, and treat inmates more in a 'batch like' way. Consequently, this will impact on their ability for self-determinism, autonomy and liberty. Privacy and confidentiality will also be compromised under such arrangements. Health care professionals then will face more stress-induced health and social problems as well as ethical and professional ones. More open institutions have less surveillance, regulation and less 'batch like' treatment. Consequently they allow for greater inmate

[20] Davies, C. Goffman's concept of the total institutions: criticisms and revisions, *Human Studies,* 12, 1989.

agency and independence. Therefore, more open arrangements of the minimum security facility ought to militate against the social, ethical and health problems associated with closed institutions whose primary purpose is to isolate inmates.

In the less closed, less isolated minimum security facility clinicians did not have to deal with the ethical and professional implications of security policies such as sight and sound and safe cell practice. However, ethical and professional problems arose precisely because the minimum security correctional facility was less closed and less isolated. The requirement to report intoxication was more problematic, according to informants, at the minimum security centre because inmates ventured into the community and some returned intoxicated or with contraband. Moreover, less surveillance and security meant some staff were less secure and felt more threatened by unpredictable and potentially violent inmates.

Goffman's and Foucault's analyses are clearly complementary. Foucault's strength is his analysis of disciplinary structures; Goffman his insights into the impact of those disciplinary techniques on the lives of inmates.

My main concern with Goffman's work is that he under-theorises the impact of the behaviours and attitudes which inmates bring into prison with them. This study found one of the major problems clinicians face was working with patients who have little commitment to their health and who have little understanding or interest of the importance of a reciprocal practitioner-patient relationship based on mutual trust and

responsibility. The prisoners' poor health status when they arrive in prison indicates these behaviours were formed prior to imprisonment.[21]

I do not want to suggest that prisoners are unaffected by imprisonment. Goffman's and Foucault's work unequivocally demonstrates how institutions make-up people. This however is not the complete story. Research in 1940 demonstrated that prisoners went through a process of 'prisonization', a term coined by Clemmer[22] in his classic study of prison subcultures. This term was used to describe the adoption of *new* adaptive processes by inmates in order to survive in an environment which imposed on them profound physical, social and emotional deprivation. Prisonization is adoption of an adaptive culture:

> featuring an anti-authority, pro-criminal values and behaviour code that inmates adopt and abide by upon imprisonment. Prisonised inmates are seen as opposing the institution and its representatives.[23]

Later research, however, has found that the deprivation model described by Clemmer was inadequate. It was found that prisoners import a normative system of attitudes and behaviours into the prison context.[24] Grapendaal's[25] more recent research indicates that prisoners adopt *new* adaptive processes in response to imprisonment as well as *import* a normative system of attitudes and behaviours. He argues both "situational and idiosyncratic factors contribute to ... subculture."[26] Thus Grapendaal argues for an integrative model which amalgamates both the deprivation and importation models.

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[21] Butler, T. Milner, L. *2001 Inmate Health Survey,* Corrections Health Services, Sydney, 2003.
[22] Clemmer, D. *The prison community,* Rinehart, New York, 1940.
[23] Kevin, M. *Addressing the use of drugs in prison: a survey of prisoners in New South Wales,* Research Publication No.44, New South Wales Department of Corrective Services, Sydney, 2000, p.1.
[24] Jacobs, J. Street gangs behind bars, *Social Problems,* 21:3, 1974.
[25] Grapendaal, M. The inmate subculture in Dutch prisons, *British Journal of Criminology,* 30:3, 1990.
[26] *Ibid,* p.355.

In *The Birth of the Clinic* and *Discipline and Punish* Foucault traces the shift in power from individuals to institutions. In both texts Foucault concentrates on disciplinary structures and how these practices give rise to new behaviours. Importantly, Foucault argued that the most egalitarian of punishments, the radical deprivation of liberty, was not the only or the most important function of prisons. He argued the prison's primary function was to transform or "re-make" inmates. Transformation was brought about by the disciplinary practices and techniques of surveillance and control which become internalised so individuals discipline themselves.

A Foucauldian perspective allows for a better understanding of the surveillance and disciplinary roles that health care practitioners are required to adopt. Since nurses are the primary health care providers in the prison context, their security role will be most evident. The participants of this research were required to fulfil both surveillance functions – checking if patients were intoxicated or harmed themselves, being within sight and sound of correctional officers – and disciplinary functions such as reporting intoxicated patients and those who self-harm to the custodial authorities, safe cell practice, and reporting prisoners who misbehaved to the correctional officers. The health care practitioner's role included implementing custodial directives, or as Holmes cited below argues, enforcing the prison order.

Holmes,[27] in his study of psychiatric nurses working in the correctional system in Canada, found that clinicians were both a subject of power – nurses were vested with the daily task of disciplining inmates and enforcing order – and they were also the objects of power. Like inmates, nurses too were subject to surveillance and control by

[27] Holmes, D. Governing the captives: forensic psychiatric nursing in corrections, *Perspectives in Psychiatric Care,* 41:1, 2005.

the custodial authorities. Nurses had to defer to correctional officers to obtain their cooperation in caring for their patients.

In Chapter 3 Alford's[28] critique of Foucault was discussed. Alford found that Foucault's disciplinary practices were absent from the prisons in which his research took place. Power was established by the custodial authorities by controlling the entry and exit points, not by Foucauldian disciplinary techniques. My sense is that Alford's point has merit. Power in prisons is established by disciplinary techniques but also in other ways. It is established by custodial authorities by 'not looking or caring' in Alford's sense, and it is established by prisoners by adoption of anti-authority behaviours and attitudes gained prior to and during incarceration. Foucault over emphasises institutional influences and under emphasises social influences on prisoners.

The data reported in the previous four chapters is textured and rich. It would be impossible to discuss all of the issues arising from the data; therefore I will limit my discussion to several issues. The data clearly demonstrate that clinicians are challenged, ethically and professionally, by the prison context. It is a separate issue whether they are able to fulfil their ethical and professional obligations to patients. The CHS Code of Ethics and Mission Statement sets out minimum standards for ethical and professional conduct of practitioners employed by CHS. I will examine whether clinicians can achieve these aims and requirements. My first argument is that the prison context hampers achievement of even the modest ethical and professional requirements promulgated by CHS.

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[28] Alford, CF. What would it matter if everything Foucault said about prison were wrong? *Discipline and Punish* after twenty years, *Theory and Society*, 29, 2000.

The empirical examination of ethics in problematic contexts also allows for a critique of ethical frameworks. As discussed in Chapter 2 there is contestation over which theoretical approach best accounts for ethics. I will evaluate whether the principle based ethics can account for context. My second argument is that principle based ethics, or that a version of it articulated by Beauchamp and Childress, is adequate both as a standard and a framework for ethical practice. These universally valid norms allow for assessment of moral judgments and analysing context.[29] This is not to assert that principle based ethics is the only valid approach to ethics; rather I argue that it is a legitimate and useful ethical framework for assessing the context, including problematic ones.

The question of adaptation is more difficult. In one sense it could be argued that the everyday forms of resistance – papering over windows, not reporting some incidents, and so on – constitute adaptation. And certainly some of the clinicians interviewed do adapt (or subvert) the prison rules. But adaptation can be understood in another, more malignant way, as 'going native' attests. Adaptation to challenges and security concerns may subvert the ethical and professional values of clinicians. In the literature this is discussed in terms of dual or divided loyalties. Clinicians are caught between competing and incompatible requirements – those of the institution which employs them and to their patients.

The next issue to be discussed will be consideration of the question of whether practitioners are forced to adapt their practice to accommodate prison rules and

[29] Beauchamp, T. Methods and principles in biomedical ethics, *Journal of Medical Ethics*, 29:5, 2003, p.269.

challenges. Based on the data, I will explore the tensions inherent in practising health care in the context of women's correctional centres. The third argument will be that, in the main, these tensions arise from the different and incommensurate values and goals between security and health care concerns. Unfortunately, though perhaps predicably, health care concerns, including clinician's ethical and professional standards and values, are compromised and in some cases subverted. The subordination of health care to security concerns, in turn, means that health care practitioners must take on different roles: ones in which security features prominently. The subverting of clinician's ethical and professional values, adapting their roles to include particular security concerns - those related to the security of the gaol and the gaol population - means that their relationships with individual patients are compromised.

In order to appreciate how security concerns may distort relationships, particularly between health professionals and their patients, it is essential to understand the moral significance of liberty in health care and how loss of liberty inevitably alters the provision of health care.

9.4 Liberty

Mill[30] argues liberty is necessary for becoming fully human, for being able to develop and, importantly, to flourish. It follows that depriving persons of their liberty is a significant moral issue.

[30] Mill, JS. *On Liberty,* Himmelfarb, G. (ed) Penguin, London, 1974.

Most of the practitioners interviewed raised liberty directly or tangentially. Several participants stated that imprisonment should deprive persons of their liberty, not their health care. Others spoke about how prisoners' human rights must be respected. So even though liberty rights were forfeited by inmates, other rights must be respected. None of the participants interviewed questioned the need for prisons or the moral authority by which persons are incarcerated. The coercive powers of government and its penal instrumentalities were evidently viewed by participants as legitimate.

Yet it is the legitimate coercive powers of government expressed in the radical deprivation of liberty which give rise to the various types of security arrangements found in prisons. Drastic deprivation of liberty necessitates the secure detention of prisoners to ensure the security of society as well as to punish and rehabilitate inmates. Institutions, whose primary function is coercion and transformation, are rationally organised in ways which privilege coercive and transformative arrangements. The provision of health care is not a primary consideration in the prison context. Consequently, health care is delivered in a markedly different, but not unique, context from usual practice. Clinicians work in institutions whose *raison d'être* is the radical deprivation of liberty construed as punishment or correction.

9.5 CHS Code of Ethics

The moral principles of autonomy, justice, beneficence and nonmaleficence serve as ethical guidelines for CHS staff.[31]

> The central obligation of health care providers, while respecting the patient's autonomy, is to attend to the good of the patient and avoid, prevent or minimise any harm to the patient. All procedures and treatment undertaken must be

[31] *Ibid,* p.6.

consistent with the purpose, values and goals of the Corrections Health Service.[32]

9.5.1 The Principle of Autonomy

While the (bio) ethical principles, theoretically, are equally weighted in that no single principle is pre-eminent, it is evident however, that in the health care ethics literature considerations about health care research on human subjects, and in discussions by clinicians about patient care, autonomy, by and large, has primacy. This makes sense to me at least; a core consideration in the delivery of health care must be a value which places emphasis on what the burden of illness means to individual patients, their health care needs and choices. The principle of autonomy is most evidently expressed in considerations and discussions of valid or informed consent. In this section I will briefly reconsider theories of autonomy and how such understandings might inform clinical practice. I will then show how this principle is compromised in the prison context.

Autonomy, in Beauchamp and Childress's sense, is "self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice."[33] In their framework, the principle of autonomy is understood as *respect* for the autonomous individual. For actions to be considered autonomous, three conditions must be met: intentionality, understanding, and absence of controlling influences which determine action. The first condition, intentionality, is absolute: a choice is either intentional or it is not. The other two requirements, however, are more flexible. A person may act autonomously,

[32] Corrections Health Service, *Professional and ethical guidelines for Corrections health service staff,* 4th edn, CHS, 2000, p.3.
[33] Beauchamp, T. Childress, J. *Principles of biomedical ethics,* Oxford University Press, Oxford, p.58.

Beauchamp and Childress argue, even though their ability to understand may be diminished to some degree and/or they may be subject to some level of control. Two of the conditions of autonomy, then, are a matter of degree. Thus while our autonomy is modified or restricted insofar as it is not absolute, and can be influenced by both internal and external factors, we are, nevertheless, considered autonomous in the Beauchamp and Childress' sense and according to law.

Respect, for most of the doctors and nurses interviewed, was expressed as respect for persons, rather than respect for autonomous persons. This broader notion of respect was important for several reasons, but mainly because respecting persons whose poor life experiences left them with low self-esteem was therapeutic.

The respect for autonomy approach favoured by Beauchamp and Childress differs from the procedural theories exemplified by Dworkin[34] and Frankfurt[35] (among others). For procedural theories of autonomy, whether they are structural or historical, critical reflection is required to secure autonomy. What differs between the various versions of procedural theories of autonomy, as Mackenzie and Stoljar[36] point out, is the process of critical reflection. In the health care context, autonomy refers to individuals being able to make realistic health care and treatment choices for, and by, themselves based on personal values. According to the procedural theory of autonomy, a person's values, desires, motivations and actions are irrelevant to considerations of whether persons are autonomous. What matters, rather, is whether a

[34] Dworkin, G. *The Theory and Practice of Autonomy,* Cambridge University Press, Cambridge, 1988, p.98.
[35] Frankfurt, H. Freedom of the will and the concept of persons, Christman, J. (ed) *The inner citadel. Essays on individual autonomy*. Oxford University Press, New York, 1989.
[36] Mackenzie, C. Stoljar, N. Introduction: Autonomy Refigured, Mackenzie, C. Stoljar, N. (eds) *Relational Autonomy: Feminist perspectives on autonomy, agency and the social self,* Oxford University Press, New York, 2000, pp.13-14.

person's actions have been subjected to critical reflection. In procedural, structural accounts of autonomy critical reflection of the person's values, desires, and motivations themselves ought to be subjected to critical reflection in order to secure autonomy.[37] Historical approaches aim to account for the effects of socialisation on critical reflection.

Dworkin takes a historical procedural approach. [38] He argues the process of critical reflection ought to be procedurally independent.

> Critical reflection must be understood as a capacity rather than an occurrent state, a capacity that enables the agent to reflect on and critically assess the various processes... by means of which she came to acquire her desires, beliefs, values, and emotional attitudes. The agent is autonomous with respect to these processes if she endorses them.[39]

Frankfurt argues critical reflection is hierarchical and, in effect, a two-level process. First-order desires must be reconciled through a process of reflection and examination with second order volitions.[40]

> Frankfurt identifies an agent's will with an effective first-order desire and claims autonomy, or freedom of the will, requires both that the agent exercise control over her will and that she identify, at the level of her second-order volitions with her will. Identification is the outcome of a process of reflection in which the agent distinguishes those desires that she endorses or regards as "her own" from those desires that she merely find herself with and is either indifferent to or regard as external to herself."[41]

From the above discussion it is clear that incarceration in and of itself will not totally undermine autonomy in either the respect for autonomy construction put forward by Beauchamp and Childress, or in the procedural accounts of Dworkin and Frankfurt. Incarceration will constrain many choices; the basic ones including choices about

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[37] *Ibid.* p.14
[38] Dworkin, G. *op cit,* p.98.
[39] Mackenzie, C. Stoljar, N. Introduction: Autonomy Refigured, Mackenzie, C. Stoljar, N. (eds) *Relational Autonomy: Feminist perspectives on autonomy, agency and the social self,* Oxford University Press, New York, 2000, pp.16.
[40] Zion, D. Does autonomy require freedom? The importance of options in international HIV/AIDs research. *Health Care Analysis,* 13:3, 2005, p.191.
[41] Mackenzie, C Stoljar, N. *op cit,* p.14.

living arrangements, what to eat, and so on, as well as more major choices about family, work and the like. But while these restrictions will limit the choices available they need not undermine an individual's *ability* or *capacity* to exercise their autonomy in terms of their *health choices*.

Communitarians and feminist writers have political and theoretical criticisms of both contemporary and traditional theories of autonomy.[42] This has led some communitarians and feminists to argue for a richer and more complex understanding of autonomy, one which considers the role of agency and oppression in constructions of autonomy. This reconceptualised autonomy is relational autonomy.

> The term "relational autonomy"... does not refer to a single unified conception of autonomy but is rather an umbrella term, designating a range of related perspectives. Those perspectives are premised on a shared conviction; the conviction that persons are socially embedded and those agents' identities are formed within the context of social relationships and shaped by a complex of intersecting social determinants, such as race, class, gender, and ethnicity. Thus the focus of relational approaches is to analyze the implications of the intersubjective and social dimensions of selfhood and identity for conceptions of individual autonomy and moral and political agency.[43]

Conceptualisations of relational autonomy, particularly as a means of understanding oppression and the impact of oppression on choice and decision-making, and feminist critiques of autonomy and its identification with informed consent, can provide a more nuanced and richer understanding of clinical practice in women's prisons. This will be discussed below.

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[42] Communitarian critics include Sandel, M. *Liberalism and the Limits of Justice,* Cambridge University Press, Cambridge, 1982, and MacIntyre, A. *After Virtue,* 2nd edn, University of Notre Dame Press, Notre Dame, 1984 and a good selection of feminist critiques can be found in Mackenzie, C. and Stoljar, N. *op cit.* See also Donchin, A. Understanding autonomy relationally: towards a reconfiguration of bioethical principles, *Journal of Medicine and Philosophy,* 26:4, 2001, pp365-386 for a feminist critique of (in particular) Beauchamp and Childress' principlism.

[43] Mackenzie, C. Stoljar, N. *op cit,* p.4.

McLeod and Sherwin[44] argue that traditional autonomy conceptions fail to take account of the role of oppression in compromising autonomy. Oppression, they maintain, works to: limit opportunities; undermine capacity by shaping an agents' values and desires; and internalise a "sense of social worthlessness and incompetence that is translated into a lack of self-worth and self-trust."[45] They concentrate on types of self-trust, as exercising autonomy necessarily involves an agent's ability to trust their desires, values, trust in their ability to make judgments about their desires and values (etc.) and in their ability to act in accordance with these.[46]

The authors argue that oppression subtly shapes notions of credibility and competence, with the dominant group being viewed as more credible and more competent than others, a process which is often reflected in the views of oppressed peoples. Lack of self-trust significantly reduces not only the ability to develop autonomy skills, it significantly reduces options. Given the poor socioeconomic status of most women prisoners, illiteracy, the overrepresentation of women from an Aboriginal and Torres Strait Islander background, the high number of incarcerated drug and alcohol addicted women and social attitudes to those imprisoned, these all make prisoners an oppressed group.

This has clear implications for clinicians working in women's prisons as, according to the above account of autonomy, many women prisoners lack autonomy skills. Practitioners, then, need to be aware of how oppression, socially, politically and morally, limits their patients' autonomy and consequently it behoves them to improve

[44] McLeod, C. Sherwin, S. Relational autonomy, self-trust, and health care for patients who are oppressed, in Mackenzie, C. Stoljar, N. (eds) *op cit.*
[45] *Ibid,* p.262.
[46] *Ibid.*

self-trust and the autonomy skills of their patients.[47] This will be the case in all health care interactions, but especially in cases in which sanctions may be accorded by the correctional authority or the justice system for prisoners who refuse to participate in treatment programmes.

Dodds[48] argues that the identification of autonomy both in terms of respect for and promotion of autonomy, has constrained debate about autonomy in health care. Moreover, it has caused the limitations of autonomy thus construed to be overlooked, focused the ethical concern towards the actions of the doctor in gaining consent and finally, "the focus on informed consent ignores the ways in which health-care practices influence the development and demise of the capacity for personal autonomy."[49] The linking of personal autonomy and consent in clinical practice inexorably narrows the focus to provision of information, securing consent, and acting in accordance with the patient's decisions. Dodds maintains respect for autonomy ought to be conceptualised more broadly so as to include understanding and promoting the development of autonomy.

Health care provision and services are particularly important to the development and promotion of autonomous selves in three ways. Using Meyers' conception of autonomy,[50] Dodds argues that the promotion of autonomy requires the provision of, and access to, welfare services, including universal access to health care. Without such services, many autonomous projects are curtailed. Secondly, health care institutions provide a socialising role within which autonomy skills and capacities are

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[47] Seedhouse argues practitioners must foster autonomy as it is essential to human dignity (discussed in chapter 2), Seedhouse, D. *Ethics: the heart of health care,* 2nd edn, Wiley, Chichester, 1998.
[48] Dodds, S. Choice and control in feminist bioethics, in Mackenzie, C. Stoljar, N. *op cit.*
[49] *Ibid,* p.214.
[50] Meyers, D. *Self, Society, and Personal Choice,* Columbia University Press, New York, 1989.

developed. Dodds provides the examples of long term and residential care, but equally prisons could be included. Thirdly many health care decisions require providing patients with a vast amount of support.

The argument that the promotion of autonomy requires access to health and welfare services, as posited by Dodds, does not take into account persons who are very healthy and consequently do not come into contact with such services. It does not follow that these persons are underdeveloped with respect to autonomy.

Autonomy, viewed relationally, shifts the focus from capacity and rational self-choice to political, social and moral influences on the development of autonomous selves and the role played by institutions and health care providers. Viewed relationally, many if not all prisoners lack autonomy skills. The correctional context, moreover, provides a different socialising role which inhibits not only the development and promotion of the requisite autonomy skills, but also the ability of clinicians to support and promote autonomy.

Another important feature relating to autonomy in the correctional context is how few patients are genuinely autonomous. The closing down of many psychiatric hospitals and the relative lack of community mental health care, means correctional institutions are acting as *de facto* mental health institutions. The relatively high number of women with a developmental disability and the number of women with a major mental illness means that they constitute some of the most vulnerable members of the community. Many of these women simply cannot make meaningful decisions about their health for themselves and by themselves. Yet these very vulnerable women,

with regards to their inability to exercise autonomy, are not only neglected in the bioethics literature, this problem is ignored both politically and socially.

Of the women capable of making valid and informed health care choices, many are simply not interested in making what health care practitioners consider good or wise choices. They have other interests and priorities. This is particularly distressing for the nursing staff, although it is also mentioned by some of the medical staff interviewed. The nurses frequently referred to patients 'scamming' or manipulating them to get drugs, or medical certificates. The patients' priorities, lack of interest in their health and health care and drug seeking behaviour was seen as time wasting, counter productive and detrimental. The nurses found this particularly frustrating and annoying. Patients, after all, ought to be interested in their health needs, and they ought to value the information and treatment provided by the health care professionals. Moreover, they ought to make rational and sensible choices regarding their health care and treatment as would the vast majority of patients in other more usual health care contexts. But many prisoners do not view their health as a priority.

9.5.1.1 Consent

Autonomy is closely identified with consent in the bioethics literature. As Dodds points out, consent is almost exclusively considered as a demonstration of respect for autonomy. Thus gaining valid consent means that autonomy is respected. Consent though can be compromised in the prison context by many factors, but primarily by deprivation of liberty, as well as coercion and the lack of the usual health care opportunities.

Consent is legally and morally required for (almost) all health care interventions.

> The question of consent in custodial settings is a complex one, and it is often argued that valid consent is almost always impossible in prison.[51]

Birmingham *et al,* cited above, argue that the coercion inherent in prisons renders the capacity of prisoners to exercise their autonomy in health care decisions and treatment choices ethically problematic, despite their common law rights. Levy would concur as he maintains:

> it must be questioned whether, in his or her disempowered position, the inmate can exercise truly informed and free consent.[52]

The doctors and nurses interviewed for this study mainly referred to autonomy and patient consent implicitly rather than explicitly, and there were some obvious examples of how the consent process was ignored or undermined. The data also provided examples of instances where clinicians required the patient's consent in unusual circumstances. Writing a court report which could prove counter to the patient's interests was an example. The importance of consent in this situation is clear; patients could be disadvantaged by their health information being provided to various authorities including the courts, probation and parole and so on. Health care information is routinely provided by health care professionals to other health care professionals, and usually this information is provided for the benefit of the patient. What is unusual in the prison context is the request to provide health care information on specific patients to those with no role in the provision of health care.

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[51] Birmingham, L. Wilson, S. Adshead, G. Prison medicine: ethics and equivalence, *British Journal of Psychiatry,* 188, 2006, pp. 4-5.

[52] Levy, M. Prisoners' Right to Health and Safety, Brown, DL. Wilkie, M. (eds) Prisoners as Citizens: Human Rights in Australian Prisons, The Federation Press, Sydney, 2002, p.248.

9.5.1.2 Veracity

Truth-telling in the bioethical literature is discussed as a second order principle which is derived from the principle of autonomy. Thus telling the truth to patients demonstrates respect for patient autonomy. The need to tell the truth to patients about their condition and treatment was no different for doctors and nurses in prison than in other, more usual, contexts. It was also true however, that health care practitioners working in the prison context did tell their patients other kinds of truths, ones that do not necessarily obtain routinely in other health care practice, nor did they explicitly to relate health care. Examples of this include health care practitioners reminding their patients that they had failed drug tests, and subsequently needed to be very careful around correctional staff.

The data indicated that the ethical and professional obligation of veracity was less problematic than other values in the correctional context. Most health care ethics texts relate specifically in the importance of veracity to the clinical relationship. No such discussion arose in the context of prison health care. It may be the case that deliberations of non-disclosure of health care information, particularly the diagnosis of a terminal condition, arise less in prison. Typically, most prisoners are young; however 'truth in sentencing' and 'getting tough on crime' political campaigns will lead to an older prisoner population. Increasingly appearing in the academic and professional literature are articles on this very problem.[53] Moreover many prisoners in this study have complex health care problems, particularly those with long-term drug

[53] See for example Fazel, S. McMillan, J. O'Donnell, I. Dementia in prison: ethical and legal implications, *Journal of Medical Ethics,* 28, 2002, pp.156-159; Linder JF, Meyers FJ. Palliative care for prison inmates: "don't let me die in prison". *Journal of the American Medical Association,* 298:8, 2007, pp.894-901; Lum KL. Palliative care behind bars: the New Zealand prison hospice experience, *Journal of Pain & Palliative Care Pharmacotherapy*, 17:3/4, 2003, pp.131-8.

and alcohol abuse, and yet non-disclosure of distressing diagnosis and prognosis was not raised as an issue.

It is also interesting to note that the usual 'ethical dilemmas' about truth telling and inter- professional conflict do not seem to be of concern in the prisons included in this study. Nurses and doctors did not appear to have truth telling turf wars, with nurses seen to be overstepping professional boundaries by providing medical information to their patients that doctors may have withheld.[54] Possibly, the fact that nurses deliver the primary care in prisons may mitigate some sources of inter-professional conflict. Or possibly, the stressful context in which nurses and doctors work renders such boundary conflicts irrelevant.

There were some instances when patients were not routinely told the truth. All of these were related to security. According to participants quite ordinary things such as the date and time of outside hospital and specialist medical appointments were kept from patients. When asked why this was the case, respondents replied "for security reasons." Prisoners could plan an escape if the movements were known to them.

9.5.1.3 Confidentiality

Confidentiality is another second order principle or rule. As with veracity, many bioethicists argue that we respect a person's confidentiality because it is another way of demonstrating respect for their autonomy. But unlike veracity confidentiality was seen as morally problematic. It was a seminal and highly challenging issue for mainly one reason: security concerns.

[54] See Johnstone *op cit,* for a discussion of this issue.

The requirement to maintain confidentiality is upheld in the various national and international codes relating to the treatment of prisoners.

> [T]he health professional should respect the medical confidentiality; should insist on being able to perform medical duties in the privacy of the consultation, with no custodial staff within earshot; should divulge information strictly on a need-to-know basis, when it is imperative to protect the health of others.[55]

Like health care practitioners in other contexts, clinicians working in correctional contexts maintained confidentiality was a *prima facie* rule which must be overridden for the greater good, or when the consequences of not breaching confidentiality outweigh the consequences of maintaining it. The Tarasoff case[56] is frequently cited as an example of when confidentiality should or must be overridden. In the correctional context, practitioners make similar decisions for similar reasons. So threats made by patients about health care or correctional staff, or indeed other patients, are taken seriously and the proper authorities and/or persons under threat are informed about the risk.

In the prison context there are exceptions to the ethical requirement to inform those at risk, even when it means breaching confidentiality. The incident of the nurse informing the ambulance officer that his patient had a history of taking hostages was cited by a participant as an example of an appropriate and defensible breach of confidentiality, and yet the nurse was disciplined by CHS administration. On the balance of harms it does seem ethically defensible for the nurse to warn the ambulance officer.

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[55] Dual Loyalty Working Group, *Dual loyalties and human rights in health professional practice: proposed guidelines and institutional mechanisms,* Physicians for Human Rights, University of Cape Town, 2002, p.74.

[56] *Tarasoff v Regents of the University of California* 551 P 2d 334, 1976, cited in Kerridge *et al. Ethics and the law for health professionals,* 2nd edn, The Federation Press, Sydney, 2005, p.240.

As noted in Chapter 5, prisoners are accepting of breaches of confidentiality when they believe it was a considered and appropriate action on behalf of the health care practitioner. So when one of the participants, a doctor, informed a correctional officer of the threats made against him by a prisoner, other prisoners believed this was a good thing to do. Hence the comments made by other prisoners about the mental status (she's mad) of the prisoner who made the threats.

Maintaining confidentiality however, is not necessarily straight forward. Prisoners are concerned that what they say to the health care practitioners will be reported to DCS. Thus, maintaining the balance between confidentiality and security requirements (security to others inside the prison or to the general community) requires skilled ethical judgements. Moreover, if prisoner patients believe confidentiality has been breached for inappropriate reasons, trust in the therapeutic relationship is destroyed.

At the maximum security correctional centre the requirement that all health care interactions should be within sight and sound of a custodial officer caused problems for nearly all the clinicians interviewed at that facility. CHS administration is well aware of this problem. The *2001 Inmate Health Survey* states:

> [I]n maximum and medium security prisons there is a 'sight and sound' policy whereby custodial officers must be in the physical vicinity of a clinical interaction at all times. This can lead to inmates feeling the clinical consultation is compromised.[57]

All participants found ways around the requirement unless they felt personally threatened. In some instances, clinicians reported feeling safer with a correctional

[57] Butler, T. Milner, L. *op cit,* p.59.

officer inside the consulting or treatment room or just outside of it. When their security was threatened by violent and unpredictable patients, breaching confidentiality was considered the lesser harm. It must be noted that more junior nurses and doctors tended to see more threats to self from prisoners than more experienced staff.

If it seems morally obligatory to breach confidentiality because of a greater harm, what of cases of self-harm or suicide? The custodial response to self-harming prisoners was seen as punitive, inappropriate and anti-therapeutic by many of the clinicians interviewed. Locking up such prisoners without access to appropriately trained personnel was considered by the participants as medically and ethically unconscionable. The requirement to report such cases, to violate confidentiality knowing how these patients will be treated, placed some of the clinicians in an untenable situation. Not only was violating confidentiality problematic given the treatment meted out to these patients, the medical and nursing staff were unable to influence or prohibit this practice.

Not all of the practitioners interviewed viewed the treatment of prisoners who self-harmed or the issue of whether to report them as problematic. One nurse at the maximum security centre believed such patients to be manipulative and difficult. They were time wasters. There was general agreement by the nurses at the minimum security centre that overriding confidentiality in such cases was the right and proper thing to do, mainly for the reason that the policy required them to do so. It must be noted that breaching confidentiality because a policy requires it is not an *ethical* justification. Other reasons for disclosure had nothing to do with the good of the patient: they were more about protecting one's back and one's registration status.

The most common and ethically problematic reason for breaching patient confidentially was to inform the correctional authorities about illicit intoxication. In almost all cases, security concerns and conforming to the policy were cited as reasons for such confidentiality breaches. Some research participants ignored the policy to report cases; they did so not because they thought confidentiality was binding, but because they thought it was in the best interests of the patient.

The principle of autonomy is at the very least problematic in the prison context. Prisoners have limited health care choices, have poorly developed autonomy skills and there is little time for practitioners to help them develop these. Moreover, the development of autonomy skills and its promotion are not a priority in the correctional context. Many prisoners, by virtue of medical condition (eg. mental illness) are not able to make autonomous decisions, and some patients who have the capacity for autonomy are disinterested in their health care needs. Consent, therefore, is compromised in the correctional context. It is compromised because many of the patients lack autonomy skills and because health care choices are limited by the context. Several authors working in this area argue that valid consent is meaningless because prisoners lack any real power or self-determination.[58]

9.5.2 The Principle of Justice

Rawls' account of a theory of justice is highly influential. He argues:

> [J]ustice is the first virtue of social institutions, as truth is of systems of thought. A theory however elegant and economical must be rejected or revised if it is untrue; likewise laws and institutions no matter how efficient and well-arranged must be reformed or abolished if they are unjust. Each person possesses an inviolability founded on justice that even the welfare of society as a whole

[58] Birmingham, L. *et al, op cit,* and Levy, M. *op cit.*

> cannot override. For this reason justice denies that the loss for some is made right by a greater good shared by others. It does not allow that the sacrifices imposed on a few are outweighed by the larger sum of advantages enjoyed by many. Therefore in a just society the liberties of equal citizenship are taken as settled; the rights secured by justice are not subject to political bargaining or to the calculus of social interests... an injustice is tolerable only when it is necessary to avoid an even greater injustice.[59]

For Rawls, the central concepts of justice as fairness are liberty and equality. These constitute the two principles of justice. Rawls argues that it is these two principles that would be chosen by rationally, self-interested individuals in the original position. The first principle is that: "each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others." Liberty is meaningless without equality of opportunity and access to the same basic rights. Thus, "social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all."[60]

Daniels posits a theory of just health care. [61] He argues that health care is a special need in that health is necessary for maintaining species-typical normal functioning (or those needs necessary for maintaining normal functioning). He extends Rawls' first principle – equal liberty, opportunities and basic rights – to health care. Health care, he argues, is a primary social good.

> The most promising strategy for extending Rawls's theory simply includes health-care institutions and practices among the basic institutions involved in providing for a fair equality of opportunity. Because meeting health-care needs has an important effect on the distribution of opportunity, the health-care institutions are regulated by a fair equality of opportunity principle.[62]

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[59] Rawls, J. *A theory of justice,* Oxford University Press, London, 1972, pp.3-4.
[60] *Ibid,* p.60.
[61] Daniels, N. *Just health care,* Cambridge University Press, Cambridge, 1985.
[62] *Ibid,* p.45.

Daniels goes on to argue that as health care needs are basic social goods, health care institutions ought, therefore, meet the decent minimum of health care needs. This type of argument, that health care is a primary social good and that there ought to be equality of access to a decent minimum informs and underpins the delivery of health care services to NSW correctional centres.

The CHS aims:

> [T]o improve the health of people in the New South Wales correctional system to an optimal level and to maintain the status by provision of care that is the same standard and quality as that is available to the wider community.[63]

The principle of justice in the health care context refers broadly to the "fair, equitable, and appropriate treatment in the light of what is due or owed to persons."[64] This includes both macro and micro considerations. Political and economic decisions about the allocation of health care resources to groups, including inmates, are macro considerations. As the CHS mission statement affirms, prisoners ought to have access to appropriate health care and to a standard equivalent to the wider community.

In the prison context, these macro-principles are avowed by both national and international codes, guidelines and declarations. Prisoners must have:

1. Access to health care workers and hospital services;
2. Equivalence of care with that of the general community or nation
3. Respect for autonomy in health care particularly with respect to consent and confidentiality; and
4. Adequate preventative health care.[65]

In prison, however, health care access and community equivalence are severely constrained for, as Levy argues, the health care opportunities for prisoners are restricted for political reasons.

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[63] Corrections Health Services, *op cit,* p.2.
[64] Beauchamp, T. Childress, J. *op cit,* p.226.
[65] Levy, M. *op cit,* p.240.

> [A] number of issues - constitutional, administrative and ultimately political – conspires against the provision of excellent health care services for all Australian prisoners. The responsibilities of the different tiers of government devised at the time of Federation, and their subsequent interpretation, has left prisoners poorly cared for.[66]

The Australian Commonwealth Government's decision to omit prisoners from Medibank and the current Medicare legislation, which provides for (almost) universal health care access and funding services, has effectively restricted the health care opportunities of prisoners. Most general practitioners in Australia are either self-employed or employed by private health care service providers. These practitioners may bulk bill their patients, a funding arrangement by which 85% of the scheduled fee is levied from the various State Governments under the Medicare legislation. Since prisoners lose all Medicare entitlements, effectively, they are not able to consult private practitioners. This also applies to private, for profit, hospitals and health care services. Prisoners do have access to health care from clinics located within correctional facilities and via the public health care system; that is, at Government funded hospitals and clinics. Restricting prisoners to the public health care system effectively restricts their health care choices, access and equivalence.

The right of patients to seek a second health care opinion is a common ethical and professional tenet. This practice is encouraged by clinicians and included in various ethical and professional health care codes. NSW Health includes this right in its patient charter.[67] The right to seek a second health care opinion is underpinned by the ethical principles of justice and respect for autonomy. Because persons are autonomous, their decisions ought to be respected including the decision to seek more

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[66] *Ibid.*

[67] See http://www.health.nsw.gov.au/health-public-affairs/you/charter.html. Accessed 8.3.08.

health care information. The decision to seek a second opinion concerns justice for reasons of equality. While in principle prisoners have the right to seek a second health care opinion, in reality it is virtually impossible for them to do so. Nor can prisoners request or choose their health care practitioner. This choice simply cannot be accommodated within a prison.

Problems of access and equivalence in prisons not only occur at the macro level. Ensuring access to health care for individual patients was neither straight forward nor easy. Accessing patients at the clinic was an issue raised by most of the practitioners, particularly at the maximum security correctional centre. One reason was that correctional centres were overcrowded – prisons operate over capacity but without concomitant increases in either correctional or health care staff to accommodate the increase in prisoner numbers.

Getting access to patients was also influenced by custodial concerns, usually to do with the multiple meanings of security. At the time of interviews, a number of 'lock-downs' had and were occurring. Lock-downs occur when correctional officers strike, or if there are not enough of them to maintain security. Lock-downs also occur if there is a security risk; for example a stabbing of one prisoner by another. During lock-downs, prisoners are confined to their sleeping accommodation and therefore unable to attend the health care clinics. Some clinicians also complained that their access to particular patients was blocked by difficult correctional staff. They believed some correctional officers did not think the prisoners deserved access to health care and were, at best, indifferent to making sure particular patients were called to attend the clinic to receive treatment or test results, or at worst, purposefully obstructive.

Providing access to specialist care outside the prison clinic was also an issue of micro-allocation and this proved particularly problematic due to escort arrangements. Escorts to hospitals are arranged to minimise security risks. Therefore only two medical escorts are arranged per day and these are arranged without the knowledge of the patient. These arrangements proved enormously frustrating for both patients and clinicians. Appointments which might have been set up six months previously had to be cancelled due to lack of escorts. Additional escorts could be arranged for medical emergencies, but organising these was time consuming and difficult. The story of the doctor who had to justify sending a patient out for a chest X-ray for suspected pneumonia was a case in point. The doctor was questioned by custodial staff over whether the patient really needed to go to the hospital because she did not look 'sick'.

It is the case that cancelled appointments are also an issue outside the correctional context, for example, patients are admitted to hospital for routine surgery only to find they are discharged prior to their operation due to (usually) a medical emergency, or perhaps the operating theatres are understaffed. Under usual circumstances, however, the delay is due to problems with the health facility and not problems with an outside and unrelated institution.

Access to specialist health care also proved problematic due to the attitudes of some specialists and hospital staff towards prisoner patients. The medical staff I interviewed at the minimum security correctional centres found this a particularly vexing issue. This issue also involves equivalence, as the treatment of prisoners in hospital emergency facilities was not up to the community standard. Stereotyping of

prisoners by emergency staff and the treatment of prisoners at specialist outpatient clinics was inappropriate. Some specialists had even refused to see prisoners. It took a considerable amount of skill, patience and time on the part of one doctor to have their patients seen at these clinics again.

I am not asserting that all prisoners suffer from inferior health care or poor access to health care facilities and treatments while they are incarcerated. Some inmates are more likely to access health care when they are incarcerated. The research participants maintained some of their patients were indeed healthier and better cared for inside prison than outside of it. This is certainly true of some services such as dental care. The research participants also felt women in prison received better ante-natal care than they would or did receive on the outside. Research also indicates the health benefits of imprisonment for access to HIV therapies, diabetes care and tuberculosis treatment.[68]

In terms of equivalence of care two key issues stand out in this study. These are the supply of sterile needles and syringes and the treatment of mentally ill patients. Needle and syringe exchange programs have been available since 1986 when a pilot program was set up in Darlinghurst, NSW. NSW alone has over 800 outlets which supply this equipment to people who inject drugs. The aim is to prevent the spread of blood borne diseases and this program forms part of a pragmatic strategy aimed at harm minimisation.[69] The *2001 New South Wales Inmate Health Survey* reports that the majority (84%) of women in prison had used illicit drugs. Moreover,

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[68] Levy, M. *op cit,* p.242.
[69] NSW Health, *Needle and Syringe program policy and guidelines for NSW,* NSW Department of Health, North Sydney, 2006.
Available at http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_037.pdf accessed 24.5.08

approximately one third of women were hepatitis B core-antibody positive and two thirds of women tested positive to the Hepatitis C antibody.[70]

Another way to ensure syringes and needles are clean is to provide cleaning solution. It is unclear from the data whether bleach was available to prisoners in the two correctional centres involved in this research. Participants provided conflicting information about whether Milton (bleach) was freely available, or whether it had been withdrawn. According to the *2001 Inmate Health Survey* cited previously, bleach was available but the custodial staff objected to its introduction. When it was introduced correctional staff either refused to provide it to inmates or intimidated prisoners who requested bleach. The prisoners surveyed reported "consequences" if they requested bleach, even though it is DCS policy to provide it. The prisoners also reported being searched after requesting bleach and having their names taken.[71]

There are obvious security concerns with the distribution of bleach – prisoners throwing it in someone's eyes for example – and particularly the provision of sterile needles and syringes because it might encourage inmates to use injecting drugs while incarcerated. But while the security concerns are understandable, it is a stark example of security subverting proper health care concerns.

The second key issue in which community equivalence was not reached was the care and treatment of patients with severe mental illness. Some of the most difficult times during the interviews were listening to clinicians describe the experience of patients with complex mental health problems, usually involving psychosis, and patients who

[70] *Ibid,* pp.73-74.
[71] *Ibid,* p.124. The survey also reported negative effects of the use and consequences of requesting bleach - prisoners injected more because bleach was available, drinking and injecting bleach and throwing it in someone's eyes.

self-harm. The differences in how these patients would be treated in a psychiatric hospital compared to how they are treated in the correctional context are of great concern. In a psychiatric hospital, patients would be cared for on a one-to-one basis by appropriately qualified nurses. The care these patients receive in the correctional context is not equivalent to that of the general community. It must be noted, however, that some of these patients may end up in prison because they received no care in the community.

Providing health care to prisoners is problematic in terms of both macro and micro considerations. Prisoners' health care opportunities are restricted by political decisions including, and most importantly, the decision to omit prisoners from the Medicare legislation. In terms of micro considerations, individual prisoners are unable to access a second medical opinion. Community equivalence in the care and treatment of injecting drug users is not achieved because prisoners are unable to get sterile syringes and needles. Nor do patients suffering severe and complex mental health problems receive care to the community equivalence standard.

There is a clear dissonance between the rhetoric of the CHS pronouncements and the actual health care in prisons. It is unlikely, however, that any significant alterations to the modes of confinement of prisoners will be effected in order that satisfactory and professionally satisfying provision of health care can occur. Another aspect related to justice is that health care facilities within prisons are deficient. It is strongly recommended that the prison health care facilities be upgraded.

9.5.3 The Principle of Beneficence

The idea of doing good for patients or acting in their best interests is central to the *telos* of medicine and nursing. Indeed this principle is so important the Dual Loyalty Working Group cite it as their first principle. "The health care professional should act in the best interests of his or her patient at all times."[72] The participants in this study described acting in their patients' best interests in a variety of ways. For some, it had a practical focus such as requesting clean sheets and nighties for their patients, or being concerned about the poor clinic facilities. Others acted in their patient's best interests by advocating for them. Several of the practitioners saw their patients as particularly vulnerable: vulnerable in the sense they were unable to act autonomously because of their mental health problems, or because they were transparently childish and had not learned the adult skills to successfully negotiate life, or simply because they were incarcerated.

Some clinicians bent the rules to act in their patient's best interests. The story of the young Aboriginal girl who was sexually assaulted and the nurse who refused to inform the custodial authorities of the sexual assault is an example of this. Some practitioners followed the rules and justified this by stating the rules were in the patients' best interests. Some practitioners justified following the rules because it was in the gaol's best interests. Practitioners who followed the rules would, for example report patients who were intoxicated to the custodial staff.

Other research participants wanted to act in their patient's best interests but felt they were prevented from doing so by the patients themselves. Lying, scamming,

[72] Dual Loyalty Working Group, *op cit*, p.70.

manipulation, not caring and generally not being interested in their health acted as barriers to clinicians acting beneficently. This also highlights the importance of trust in health care relationships. Patients must trust that their health care practitioners are acting in their best interests. Many inmates were very trusting, providing information about their criminal history and drug use both inside and outside prison. In numerous ways many of the patients were very open, surprisingly so for some of the participants. One reason for such trust might be that the patients are aware that medical records are confidential, though this is unlikely given that 42% of women inmates' surveyed believed medical information was shared with custodial staff.[73] It may be that inmates felt the health care professionals were especially trustworthy. Or it may be that nothing is private in prisons. Trust in prisons, though, is brittle. Respondents spoke of how easily trust could be destroyed because the inmates' expectations or desires had not been met.

The literature usually discusses the importance of trust in terms of patients trusting their doctors and nurses. In the prison context trusting *patients* is problematic. This is demonstrated by clinicians not knowing if their patients are lying, scamming or manipulating them for their own ends. If, as Beauchamp and Childress assert, trust involves confidence "that another will act with the right motives and appropriate moral norms,"[74] then doctors and nurses cannot trust their patients. Nor can clinicians trust their patients in the sense meant by Rogers and Braunack-Mayer. Clinicians cannot trust that their patients are genuinely seeking medical care, nor trust that they are telling them the truth, nor trust that they will cooperate with treatment goals.[75]

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[73] Rogers, W. Braunack-Mayer, A. *Practical ethics for general practice,* Oxford University Press, Oxford, 2004, p.59.
[74] Beauchamp, T. Childress, J. *op cit,* p.34.
[75] *Ibid,* p.21-22.

Moreover, clinicians working in the correctional context cannot trust that their patients will not harm them.

Practitioners must be wary of their patients – indeed it may be foolish to trust them – and this inevitably harms the practitioner-patient relationship. Lack of trust also accounts for the feelings of frustration, anger and fear articulated by (mainly) nurses. This inability to trust patients inevitably makes it more difficult to fulfil the ethical obligation required by the principle of beneficence.

While it not easy for clinicians to always act in their patient's best interests, and many factors complicate this, custodial policies severely militate against clinician's presumptive beneficent obligations. Reporting of self-harm and safe cell practice and the lack of a sterile needle and syringe exchange program were the examples used for demonstrating how correctional requirements interfere with justice obligations. These two examples also show how security concerns subordinate the clinician's ability to act in their patient's best interests. But equally, the various security requirements have an important impact on other health care practices. The requirement to report intoxication and assaults, security classifications which may mean mothers are unable to have their babies with them, rules which forbid women to express breast milk in front of correctional officers, handcuffing women in labour, and more, all demonstrate how correctional and security requirements in terms of the detention of prisoners (rather than personal security concerns) subvert health care concerns and the ethical and professional obligations of clinicians.

9.5.4 The Principle of Nonmaleficence

The Hippocratic principle to do no harm is often used in conjunction with the principle of beneficence. As discussed in Chapter 2, Beauchamp and Childress argue that this principle is often expressed as the legal duty of care. A clinician's duty of care takes on a different role in the prison context – different that is from usual practice. In the prison context (and mainly by the nurses) the duty of care was construed as the obligation to inform the correctional authorities about intoxication, assaults and self-harm. Nonmaleficence had utilitarian value. The duty of care was extended to include the whole prison, so reporting ensured harm was minimised.

Preventing harm then was central to notions of duty of care associated with reporting intoxication and assaults to correctional staff. One of the nurses interviewed made judgments about whether to report intoxication to the authorities based on what drug an inmate had used. If the inmate had ingested Rohypnol, for example, the nurse would inform the custodial authorities, not only because the nurse had a duty of care for the particular patient, but also because the nurse had a duty of care to all other inmates.

Other nurses respond to such situations differently. They considered the implications of reporting cases of intoxication because when inmates are found to have taken drugs they are punished. The consequences of reporting are harm to the patient. Some nurses then, take a harm minimisation approach to health care and this is in direct opposition to the zero tolerance approach taken by the custodial authorities. This point is important as it demonstrates that different values are held by clinicians to custodial authorities.

As stated above, some of the clinicians interviewed used the principle of nonmaleficence to protect their patients from harm - roughly construed as a duty of care and protection from risk - while some extended this principle to protect others from harm. There are instances, however, when clinicians are unable to do no harm or protect patients from harm, even when they have a moral obligation to do so. The most obvious example of this is the treatment of inmates who self-harm. Clinicians are unable to protect these patients from a treatment they consider harmful.

Many of the women suffering from a mental illness should be in a hospital and not in a prison. The clinicians do their best to ensure that patients who should be in hospital are either transferred to one and that they have appropriate legal representation (not jobs usually required of clinicians). Nurse, Woodcock and Ormsby studied the influence of the environment on mental health in a local prison in southern England. They argue isolation, lack of mental stimulation, drug misuse, lack of family contact, a negative relationship with staff, bullying, but mainly "long periods of being locked up with little activity or mental stimulation have a negative impact on the mental health of prisoners, whether nor not they had a formal mental illness."[76] Moreover, staff experienced increased stress due to reduced staffing levels, prison culture, fear of their safety, and poor management style. The mere fact of being in prison worsens health. Clinicians are unable to protect their patients from harm when they are made sick or worse by incarceration.

[76] Nurse, J. Woodcock, P. Ormsby, J. Influence of environmental factors on mental health within prisons: a focus group study, *British Medical Journal*, 327:480, 2003, p.483.

9.5.5 Evaluation of Codes and Ethical Frameworks

A code of ethics is an important document which sets out the minimum ethical standards expected of professionals. This research shows that the clinicians interviewed obviously try to fulfil their ethical and professional obligations to patients as set out in professional, institutional, national and international codes, guidelines and declarations. Fulfilling even these general moral obligations, however, remains problematic. Clinicians find it difficult to fulfil even the modest ethical requirements set out in the CHS code of ethics. I am not arguing that this is the fault of the clinicians, indeed most of the professionals I interviewed impressed me by their genuine desire to do the best for their patients. The main reason why the clinicians could not discharge their ethical obligations was primarily because health care considerations were subordinated to security concerns. This will not come as a surprise to CHS staff, both clinical, research and administrative. Ensuring access to health care and community equivalence in the prison context was never going to be easy or achievable.

The prison context creates and gives particular shape to ethical issues and problems faced by clinicians. We can assess this because the framework of moral principles, values and rules articulated by Beauchamp and Childress provide a standard of valid norms by which we can adjudge deviance from good ethical practice, and more importantly, we can assess context. Beauchamp and Childress argue that abstract principles need to be specified to allow for the analysis of context. Specification "is a process of reducing the indeterminateness of general norms to give them increased action guiding capacity, while retaining the moral commitments in the original

norm."[77] Specification requires narrowing the scope of the general norms and by "spelling out where, when, why, how, by what means, to whom, or by whom the action is to be done or avoided."[78] Analysing context also involves the process of weighing and balancing. Weighing and balancing concerns "the relative weights and strengths of different moral norms."[79] Principles are thus contextualised by narrowing the scope and balancing the moral norms.

Many of the health care practitioners interviewed for this research demonstrated an understanding of contextual professional moral norms. They specified and balanced the moral principles according to their specific context. For example when one nurse was discussing whether or not to report an intoxicated inmate they considered the implications of their decision. What would the impact be of reporting this situation on the patient, and on the patient's family, particularly her children? Some clinicians were very good at this type of thinking and reasoning. Others were more evidently rule bound.

In the following section I will explore the question of adaptation. I will argue that the inherent and necessary tensions between health care goals and values and the correctional goals and values of security and protection, compromise the clinician-patient relationship. It is also an argument about how context not only challenges ethical and professional values, it creates them.

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[77] Beauchamp, *op cit.*
[78] Richardson, H. Specifying, balancing and interpreting bioethical principles, *Journal of Medicine and Philosophy,* 25, 2000, p.289, cited in Beauchamp T. Childress, J. *Principles of Biomedical Ethics,* Oxford University Press, New York, 2008, p.17.
[79] Beauchamp and Childress, *Ibid,* p.20.

9.6 Tensions and Adaptations

In this section I will discuss the tensions evident in prison; tensions that, from an outsider's perspective, seem to be the defining feature of the context. I will then argue that these tensions arise from the different values and goals between health care and correctional concerns, with correctional concerns privileged.

Tensions are a feature of many interactions in prisons. Taken from one perspective this tension is healthy. Its presence demonstrates the conflict of values between CHS and DCS. And this is a good thing: lack of tension would be evidence of widespread and profound acculturation. To limit the problem of acculturation and dual loyalties, health care is provided by an independent organisation. This approach is recommended by the AMA code and, I would argue, the best and most appropriate model for delivering health care to Australian prisoners.

Tension then is inevitable. This tension, however, is not merely tension between groups with opposing values and goals, in which balance is reached. Health care concerns and values are subordinated to security requirements. One could imagine a prison in which the delivery of health care was given equal weight to security. This prison would look and run in an entirely different way to the current model. Many of the problematic ethical issues that clinicians face – safe cell practice, no needle and syringe exchange programs, sight and sound policies, etc., would no longer be 'issues' as they are in the current context. They become problematic issues because the various security concerns are primary and all other concerns subverted.

The most evident tension is between custodial staff and health care staff. At a local level – in the clinic – it is manifested as conflict between correctional officers and clinicians. The main issue is tension between different values. Clinicians are

employed to provide health care, correctional officers are employed to manage offenders and ensure a safer community.

At the minimum security correctional centre, tension between the two groups was usually over the issue of personal safety. The nurses in particular felt that the correctional officers did not do enough to protect the clinical staff. The nurses were distressed at what they believed was a double standard when custodial officers enforced discipline when inmates were abusive to officers but ignored abuse from inmates when it was directed at nurses. Some of the nurses spoke about the abuse as a threat to their personal safety; other nurses wanted such behaviour punished because the treatment of prisoners was too lenient. In these cases the values tension was reversed.

Another example of conflicting values was expressed in the clinicians' descriptions of 'lock-downs'. As already noted lock-downs occur for several reasons. Health care practitioners understood, usually, why these occurred, but the fact that security concerns always overrode important health care concerns deeply annoyed clinicians. Doctors and nurses still needed to see their patients, despite security or industrial concerns. Little consideration was accorded to health care priorities.

Tension due to competing values was also evident between clinicians and DCS administration, though this was mainly an issue at the maximum security facility. Clinicians resented being treated as 'underlings' of the correctional administration. They viewed themselves as autonomous. They also resented it when correctional and security policies and procedures took precedence over medical care and treatment.

Tensions in and between other groups were also evident in the participants' accounts, including the view that CHS administration were too far removed from the coal face. At times the priorities and values of CHS seemed at odds with the real world of caring for difficult, destructive and sometimes violent inmates. There was criticism of some of the senior CHS medical staff's values and behaviours by some of the nurses. There was also criticism of some nurses by other nurses for being judgmental about patients. One damning comment made by several of the nurses interviewed at the maximum security prison was occasioned by this research. Apparently it was the subject of lunch time conversation. One nurse, who did not choose to participate, was overheard saying that she could not think of any ethical issues in prisons. This view was mirrored by one medical participant, though the doctor had a more complex view. The doctor maintained there was no difference in the ethical issues inside and outside gaol. All those interviewed who dealt with outside health care agencies and clinical staff complained about the judgmental and unrealistic attitudes of these agencies to inmates. Conflicting values also gave rise to tensions between CHS practitioners and Probation and Parole officers, DCS solicitors and other legal entities.

Apart from DCS staff, the next most important group in which tension and conflict was clearly evident was the patients. Both nurses and doctors found patients problematic in that they had very different and divergent views about the importance of health care. According to participants, patients were more respectful to, and compliant with, the medical staff. After all it is doctors who prescribe drugs. Nurses, as the ones who provide primary care, were more present for the patients and consequently reported more abuse than doctors. Nurses were also the ones who staffed the pill window and either refused requests for non-prescription drugs or restricted the amount provided. This too was the occasion for abuse. Nurses spoke in

terms of 'winning and losing', and 'them' and 'us': terms unselfconsciously and frequently used in the ways nurses described their interactions with patients. All this indicates how resentful nurses felt about patients who manipulated, abused and scammed them. The theory of prisonization provides an explanation for the amount of abuse nurses were subjected to. Gender is also an issue here. I suspect women inmates abused the nurses far more than men inmates would or did. I think this explains comments made by nurses about how much more difficult, violent and generally more awful, women inmates were in comparison to men.

The threat of violence, often unpredictable, also caused fear, anxiety and tension for clinicians. Several participants recounted the experience of one nurse at the minimum security facility being bailed up by an aggressive inmate without being assisted by correctional officers. Fearful stories, often about the experiences of other people, but occasionally themselves, were usually narrated by inexperienced clinicians and the telling confirmed and reinforced to them how deeply scary prison was – even in the minimum security facility. The real need to be on guard, ever vigilant, never trusting was palpably distressing and a source of deep anxiety for the clinically junior and often younger clinicians.

Thus far I have argued that the conflicting values in and between CHS staff and DCS staff create tensions. These are inevitable given the different aims and commitments of each group. There were many examples of how custodial and the various types of security concerns interfere with or subvert the legitimate health care concerns and procedures.

Privileging and prioritising the security concerns which are necessary for the detention of inmates and for the good of the prison, forces clinicians to adapt their

practice – and take on new, non-clinical roles - in ways which compromise their relationships to patients. In prison, clinicians are *required* to act against their patient's best interests for security reasons and for the greater good. Clinicians are *required* to violate confidentiality to *non-health care* authorities, all of which subordinate and pervert the clinician's moral and professional obligations for utilitarian, security reasons. Nor is professional judgment allowed if it interferes with security arrangements, despite the fact that individual patients may be harmed by the policy requirements. This adaptation of the clinician's role is inconsistent with the *telos* of medicine and nursing and inconsistent with clinicians' ethical and professional responsibilities.

In Chapter 7 clinicians spoke about the need for discipline and order, about classifications, policies, procedures, documentation, which are all important considerations, and all of which express a significant security function. The CHS *Professional and Ethical Guidelines* makes clear that clinicians must be mindful of security issues. The following quote is in relation to practice guidelines and sexual conduct with patients.

> The correctional environment and the inherent risks in which a clinician works must always be borne in mind. As well as health concerns there are security concerns.[80]

But I am making a stronger claim. The data indicate that clinicians have to do more than be aware or mindful of security concerns; security is part of their role.

Simon argues "[P]rison psychiatrists often have to choose between serving prisoners, prison officials, or society."[81] The requirement for health care professionals to take on

[80] Corrections Health Services *op cit*, p.18.

a security role is an instance of dual loyalties. Clinicians working in the prison context must not only be mindful of security concerns as a protective function, they must be mindful of them for the security of the gaol. This is not an option; it is mandated. This adds a further layer of ethical and professional complexity to clinical practice in the prison context because it means ethical and professional values are subverted to security concerns and values. The requirement to take on dual roles creates another source of tension.

One consequence of requiring security for the good of the gaol as part of clinical practice is that the clinician-patient relationship is compromised. Ethical values of confidentiality and trust, beneficence and nonmaleficence will inevitably be compromised. This mandated security role means that the good of the gaol will override the good of individual patients. While it is true that the clinician-patient relationship is compromised by role adaptation, it is also compromised by other factors. Even if health care professionals could or did eschew their security role, the fact that custodial concerns are primary means that the clinician-patient relationship, core to which is patient autonomy and best interests, is automatically compromised.

The purpose of prison, depriving people of their liberty, also functions directly to complicate, if not compromise, the clinician-patient relationship. Clinicians spoke about the need for impartiality. This meant more than treating all patients equally (if this ever is possible or even desirable) and more than giving in to manipulative patients who will only be attended to by their 'special' nurse, it meant not getting too close to their patient, and trying not to make any of them feel too special. The view

[81] Simon, RI. *Clinical psychiatry and the law,* American Psychiatric Press, Inc, USA, 1987, p.18.

that intimacy is problematic is specifically addressed in *Professional and ethical guidelines for Corrections Health Service Staff* as a boundary issue. Staff are reminded to keep a professional distance for the best interests of inmates because they:

> have so little opportunity for genuine human interactions... [and] have little private life... Inmates are deprived of personal relationships during their incarceration and are therefore in no position to act out a relationship.[82]

It is ethically wrong to enter into sexual relationships with inmates for a variety of reasons, however it seems that intimacy – in the therapeutic sense of the word – is also ruled out. The compassionate and caring touches, making someone feel special when they are depressed, holding someone's hand when you give them bad news are prohibited. All those gestures of human contact and kindness make such a difference to patients because it lets them know that, as a person, they matter to the nurse or doctor, and that what happens to them matters. These, it seems, are proscribed. So even if health care professionals could or did eschew their security role, the radical deprivation of liberty that renders inmates vulnerable to exploitation, and the fact that correctional concerns are primary, means that the clinician-patient relationship is further compromised.

It must also be noted that there is a history of boundary violations between nurses and prisoners in correctional contexts. In NSW 3 cases of have been heard before the Nurse and Midwives Tribunal in the past 12 years, where CHS nurses have become emotionally and sexually involved with inmates.[83]

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[82]Corrections Health Services *op cit*, p.14.

[83] See Keatinge, D. Chiarella, M. *Professional Conduct: A case book of disciplinary decisions relating to professional conduct matters,* Nurses Registration Board of New South Wales, Sydney, 2001, pp.

9.7 Conclusion

This thesis has explored how the prison context impacts on the clinician's ethical and professional health care practice via examination of health care professionals' experience. More specifically, the project aimed to understand the limits and possibilities of clinical freedom in confined contexts and to examine the adequacy of ethical principles and codes of ethics for explaining or describing the ethical obligations of health care practitioners working in the prison context.

The evidence from this study showed that clinicians found meeting their ethical and professional obligations to patients as required by the CHS Code of Ethics problematic. Respecting patient autonomy was difficult because a prisoner's health care choices were constrained by political policies and security arrangements. The patients themselves have poorly developed autonomy skills which further limited their health care options. Attempting to rectify this by promoting autonomy and the autonomy skills of patients was not a priority in the correctional context. Maintaining confidentiality also proved difficult in this context. Clinicians breached confidentiality to prevent harm to self and others, and for the good of the gaol. Violating confidentiality obligations for the good of the gaol was the clearest example of the context subverting the clinician's presumptive ethical obligations to patients. Justice obligations too were compromised by context. Evidence of this was found in political and security policies and practices which prevented clinicians from providing the equivalent community standard of care to inmates, or which restricted an inmate's access to health care. The duties to do good and refrain from harm were similarly undermined. Clinicians were unable to act in their patient's best interests if the good

246-247, and *Cunningham v Health Care Complaints Commission (HCCC)* NSWNMT available at www.auslii.edu.au.

of the gaol was at issue. Nor could they prevent harm if imprisonment caused ill-health.

The security requirement to adapt clinical practice to context also compromised the clinician-patient relationship. The security roles required of clinicians subverted their ethical and professional values. In the literature this is discussed in terms of dual or divided loyalties. Clinicians are caught between two competing and incompatible requirements – those of the institution which employs them and those of their patients.

Here, and throughout this work, I am committed to the view that the most insightful descriptions of the ethical plight of health care workers in prison contexts is per medium of the terms central to principle based ethics. Principle based ethics has been criticised for individualistic bias,[84] its inability to account for emotions,[85] and its poor means of detecting errors in argument,[86] among other reasons. I do not deny the critics of principle based ethics have grounds for criticism. The four principles alone do not allow for textured or sophisticated analysis of ethical issues. This is why codes of ethics are insufficient as an ethical framework or standard: they use principles as placeholders devoid of any theoretical depth. However, Beauchamp and Childress' principle based frameworks which attend to scope, balancing moral norms, argument and context[87] do provide an appropriate framework for analysing practice in context and as a standard for moral deviance.

The most basic and significant difference between prison inmates and free citizens is the legally coerced lack of liberty of the former. As my work has shown,

[84] Callahan, D. Principlism and communitarianism, *Journal of Medical Ethics,* 29:5, 2003.
[85] Gardiner, P. A virtue approach to moral dilemmas in medicine, *Journal of Medical Ethics,* 29:5, 2003.
[86] Harris, J. In praise of unprincipled ethics, *Journal of Medical Ethics,* 29:5, 2003.
[87] Beauchamp, T. Childress, J. *op cit.*

arrangements within prison give structure to this condition of unfreedom: through policies which regiment times and places of activity, which restrict and regulate social interaction with inmates and outsiders, and which compel various agents to report details of inmates' situation to authorities – details which would be matters of privacy and confidentiality in counterpart circumstances outside the prison. These features are not merely contingent; they are essential to current institutional modes of corrective services. But these features, the material core of an unfree life, are also inimical to the reasonable ideals of provision of good health care.

Therapeutic benefit is best realised in a context in which there is mutual trust between carer and client, and in which the carer's professional service is at the disposal of the client: to be received and reviewed in terms of the client's ongoing life, a life which involves a satisfying range of projects and social involvements, and where the style, pace and direction of these projects and involvements is determined by the client himself or herself. What counts as health and well-being for any particular person must be dependent, in good part, on the nature of their chosen life pattern. This thesis has shown that such a therapeutic context is not, and cannot be, available in prisons as currently organised – for the reasons indicated above. Current arrangements for the organisation of life in the prisons mean that there is little scope for robust and ongoing mutual trust between carer and client, and severely restricted scope for the exercise of choice regarding a satisfying style of life. Because these arrangements are central to prison function, they will provide at best a distorted context in which health carers encounter inmate clients, and one which compromises the quality of health care possible. The carers' registration of this profoundly unsatisfactory situation is evident in their accounts of their experiences – as discussed in this thesis.

A clear implication of this finding is that satisfactory, and professionally satisfying, provision of health care to prison inmates will not eventuate unless there is a significant alteration to the modes of confinement of inmates. A further implication is that, unless such alteration is effected, the official commitment of CHS to the principles of community equivalence and equality of access to health care for prisoners, relative to the access available to free citizens, cannot be met.

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Appendix A: Ethics Approvals

ETHICS APPLICATION FORM FOR RESEARCH INVOLVING HUMANS



THIS APPLICATION MUST BE TYPEWRITTEN

ALL QUESTIONS MUST BE ANSWERED

USE LAY TERMS WHEREVER POSSIBLE

DO NOT ALTER THE LAYOUT OR PAGINATION OF THE APPLICATION FORM

"Y" SIGNIFIES YES AND "N" SIGNIFIES NO

NOTE: SOME "Y"/"N" BOXES HAVE BEEN REVERSED

SECTION 1: ADMINISTRATION AND SUBMISSION TO OTHER INSTITUTIONAL ETHICS COMMITTEES (IECs)

1.1 (a) Full project title

Exploration of Ethical Dilemmas and Issues faced by Nurses and Doctors Working in Female Correctional Centres in NSW

(b) Short name by which the project will be known (if appropriate)

(c) Name of Chief Investigator

Robert Heard

(d) Provide a brief lay description of the project (in less than 100 words).

The purpose of the proposed research is to explore and describe the ethical dilemmas and issues commonly encountered by doctors and nurses employed by Corrections Health Service, and working in female Correctional Centres in NSW. The method employed will be semi-structured in depth interviews of 12 currently employed health care professionals. They will be asked to describe ethical issues encountered in their jobs. The study is intended to inform Corrections Health Service of the ethical issues faced by clinicians which may assist in the formulation of policy, the education of current staff, and in the orientation and training of new staff members.

1.2 Indicate the institution that you consider to be the primary site for this research project.

Mulawa and Emu Plains Correctional Centres

Acknowledgments.

The assistance of the following in producing this form is gratefully acknowledged: Mrs Gail Briody (University of Sydney), A/Professor David Cook (University of Sydney/Central Sydney Area Health Service), Professor Simon Gandevia (University of NSW), Dr Rob Loblay (University of Sydney/Australian Health Ethics Committee), Mr Ted McKeown (Hunt & Hunt), Ms Lesley Townsend (Central Sydney Area Health Service), Dr John Watson (University of Sydney), Mrs Margaret Wright (University of NSW).

1.3 List the following details of the Chief Investigator/Supervisor, any Co-Investigator, Associate Investigator and Student. (If necessary, insert extra pages to follow this.)

Chief Investigator/Supervisor

- **name** Robert Heard
- title Dr
- qualifications BA(Hons) PhD USYD
- positions held Senior Lecturer, University of Sydney
- full mailing address Faculty of Health Sciences, The University of Sydney
  Cumberland Campus
  East St
  Lidcombe NSW 2141
- telephone number (02) 9351 9498
- fax number (02) 9351 9540
- e-mail address R.Heard@fhs.usyd.edu.au

Co-Investigator(s), Associate Investigator(s) or Student

- **name** Damian Grace
- title Associate Professor
- full mailing address School of Social Work
  Faculty of Arts & Social Sciences
  University of NSW
  Kensington 2033
- telephone number 93851010

- **name** Karolyn White
- title Ms
- full mailing address Faculty of Nursing, The University of Sydney
  88 Mallett St Camperdown 2050
- telephone number (02)93510581

1.4 (a) Indicate the proposed date of commencement of the project. Researchers are reminded that projects may not commence without the written approval of the Institutional Ethics Committee (IEC).

March 2001

(b) Indicate the proposed duration of the project.

Three months

1.5 Indicate the location at which the research will be undertaken.
Mulawa & Emu Plains Correctional Centres

1.6 (a) Is this submission being made as part of an application for research funding ? ☒ N ☐ Y

If you answered **YES**, list the funding bodies to which you have submitted, or intend to submit, this project.

(b) If the title of the project submitted for funding is different from that listed under Question 1.1, state it below.

1.7 Has this project been submitted to any other IEC(s) ? ☐ N ☒ Y

If you answered **YES**, give the name of the IEC(s), and indicate the status of the application at each (i.e., submitted, approved, deferred or rejected).

The project will be submitted to the University of Sydney Human Ethics Committee if it is approved by this Ethics Committee

Attach copies of the correspondence with each of the other IEC(s).

SECTION 2: NATURE OF RESEARCH INCLUDING RISKS

2.1 The nature of this project is most appropriately described as :

(a)	A clinical trial of drug(s) or device(s)	[x] N	[ ] Y
(i)	under the Clinical Trial Notification Scheme (CTN)	[ ] N	[ ] Y
(ii)	under the Clinical Trial Exemption Scheme (CTX)	[ ] N	[ ] Y
(iii)	using only approved drug(s)/device(s) in accordance with Therapeutic Goods Administration Approved Product Information	[ ] Y	[ ] N
(b)	Human physiology research	[x] N	[ ] Y
(c)	Human tissue research	[x] N	[ ] Y
(d)	Psychiatry/clinical psychology research	[x] N	[ ] Y
(e)	Behavioural research	[ ] N	[x] Y
(f)	Biomechanical research	[x] N	[ ] Y
(g)	Research using a questionnaire only	[x] N	[ ] Y
(h)	Research using qualitative methods	[ ] N	[x] Y
(i)	Other (indicate the nature of the research below)	[x] N	[ ] Y

2.2 (a) Does the protocol require any physically invasive, or potentially harmful procedures (e.g. drug administration, needle insertion, rectal probe, pharyngeal foreign body, electromagnetic stimulation) ? [x] N [ ] Y

If you answered **YES**, state the nature of the procedures, all the risks involved and, if possible, at what rate these risks are expected to occur. (All this information must be included in the Subject Information Statement.)

(b) If you are doing research on patients, list the procedures/techniques which would not form part of routine clinical management.

2.3 Will human placental tissue be used ? [x] N [ ] Y

2.4 Will human embryos or fetal tissue be involved ? [x] N [ ] Y

2.5 Will human tissue be collected for culture or any other purpose ? [x] N [ ] Y

2.6 Will somatic cell gene therapy be used ? [x] N [ ] Y

2.7 Will recombinant DNA techniques be used ? [x] N [ ] Y

2.8 Will toxins, mutagens, teratogens or carcinogens be used ? [x] N [ ] Y

2.9 Will subjects or researchers be exposed to ionizing radiation ? [x] N [ ] Y

If you answered **YES**, provide details of the radiation exposure, including a quantitative assessment of the absorbed dose, supported either by dosimetric calculations or by other information.

2.10 Please list any drugs/devices to be used, and their approval status both overseas and in Australia.

N/A

2.11 Is this research expected to benefit the subjects directly or indirectly ? [ ] N [x] Y

If you answered **YES**, provide details.

It is expected that the research will assist in the formulation of policy and service delivery, the education of staff, and the preparation of accreditation documents which may indirectly benefit the employment conditions of the participants. There will be no direct benefits to participants.

2.12 Will the true purpose of the research be concealed from the subject(s) ? [x] N [ ] Y

If you answered **YES**, provide details of the concealment and any debriefing.

2.13 Will the research induce any psychological or physical stress in the subject ? [ ] N [x] Y

If you answered **YES**, state what form this stress will take.

It is possible that recalling memories of events which posed ethical dilemmas may cause psychological distress to some participants. If a participant becomes distressed the interview will be suspended. The Corrections Health Employee Assistance Scheme will be alerted, at the time of the interview or later if necessary, to counsel any participants who experience distress.

2.14 Could participation in the research adversely affect the subject(s) ? [x] N [ ] Y

If you answered **YES**, what facilities/trained personnel are available to deal with such problems?

SECTION 3: INDEMNITY, COMPENSATION AND POSSIBLE CONFLICT OF INTEREST

3.1 (a) **Will this research be undertaken on behalf of (or at the request of) a pharmaceutical company, or other commercial entity, or any other sponsor ?**

[x] N [ ] Y

If you answered **YES**, will the sponsor provide support in money or kind? Provide details.

(b) **If you answered YES to (a), will that entity undertake in writing to abide by either the ABPI Clinical Trial Compensation Guidelines or the APMA Guidelines for Injury Resulting from Participation in an Industry–Sponsored Clinical Trial ?**

[ ] Y [ ] N

(c) **If you answered YES to (a), will that entity undertake in writing to indemnify the institution, the IEC(s) and the researchers ?**

[ ] Y [ ] N

(d) If you answered **YES** to **(a)**, **(b)** or **(c)**, does the sponsor hold a current insurance policy to cover this project ? If you answered **YES**, provide a certificate of currency. If you answered **NO**, provide details.

[ ] Y [ ] N

3.2 **Do the researchers have any affiliation with, or financial involvement in, any organisation or entity with direct or indirect interests in the subject matter or materials of this research ?**

[x] N [ ] Y

If you answered **YES**, provide details.

3.3 **Do the researchers expect to obtain any direct or indirect financial or other benefits from conducting this project ?**

[x] N [ ] Y

If you answered **YES**, provide details.

3.4 **Are there any further ethical considerations that you wish to raise ? For example, have conditions been imposed upon the use, publication or ownership of the results ?**

[x] N [ ] Y

If you answered **YES**, detail what these considerations are.

SECTION 4: SUBJECTS

4.1 Are the subjects :

– 0 - 13 years of age?	[x] NONE	☐	☐
SOME ALL			
– 14 - 16 years of age	[x] NONE	☐	☐
SOME ALL			
– 17 years of age or over ?	[x] ALL	☐ SOME	☐ NONE

4.2 Are the subjects :

– unconscious or critically ill patients ?	[x] N	☐ Y
– mentally ill ?	[x] N	☐ Y
– wards of state ?	[x] N	☐ Y
– prisoners ?	[x] N	☐ Y
– members of the armed services ?	[x] N	☐ Y
– in a doctor–patient relationship or a health giver–receiver relationship with the researchers or their associates ?	[x] N	☐ Y
– in a teacher–student relationship with the researchers or their associates ?	[x] N	☐ Y
– in an employer–employee relationship with the researchers or their associates ?	[x] N	☐ Y
– in any other dependent relationship with the researchers or their associates ?	[x]	☐

4.3 If the subjects are to undergo a medical or other procedure are they :

– capable of understanding the general nature and effects of the proposed treatment ?	☐ Y	☐ N
– capable of indicating whether they consent or do not consent to the proposed treatment ?	☐ Y	☐ N
If you answered **NO** to either of the above, is the treatment a new treatment that has not yet gained the support of a substantial number of medical practitioners or dentists specialising in the area of practice concerned ?	☐ N	☐ Y
– Has the treatment been declared to be special treatment under the terms of the Guardianship Act 1987? (as amended).	☐ N	☐ Y

SECTION 5: RECRUITMENT OF SUBJECTS

5.1 (a) How many subjects will be recruited?

Twelve, six doctors and six registered nurses.

(b) How will the subjects be recruited?

Two Corrections Health Service staff (one doctor and one registered nurse) have agreed to randomly select names of potential participants and provide them with the Subject Information Statement and Consent Form. Potential participants will be invited to contact the researchers.

5.2 (a) Does recruitment involve a direct personal approach from the researchers to the potential subjects ? [x] N [ ] Y

If you answered **YES**, is there any pressure from researchers or others that might influence the potential subject to enrol ? [ ] N [ ] Y

If you answered **YES**, explain.

(b) Does recruitment involve the circulation/publication of an advertisement, circular, letter, etc? [x] N [ ] Y

If you answered **YES**, provide a copy and indicate where and how often it will be published.

5.3 Will subjects receive any financial or other benefits as a result of participation ? [ ] N [x] Y

If you answered **YES**, what is the amount/benefit and the justification for this ?

The participants may receive some indirect benefits. Please see Section 2.11 for an explanation.

5.4 Is the research targeting any particular ethnic or community group ? [x] N [ ] Y

If you answered **YES**, which group is being targeted?

If you answered **YES**, has this been done in consultation with a representative of this group ? [ ] Y [ ] N

If you have not consulted a representative of this group, give reasons.

If you have consulted a representative, who have you consulted and how do they represent this group?

SECTION 6: PRIVACY AND PUBLICATION OF RESULTS

6.1 Is there a requirement for the researchers to obtain information of a personal nature about individuals without their consent :

- From Commonwealth departments or agencies ? [x] N [ ] Y

- From other third parties, such as universities, hospitals, State government agencies or employers ? [x] N [ ] Y

If you answered **YES**, state what information will be sought and why written consent will not be obtained from the individual subjects.

6.2 Will any part of the experimental procedures be placed on audio tape, film/video, or other electronic medium ? [ ] N [x] Y

If you answered **YES**, what is the medium and how it will be used ?

Interviews will be audio tape recorded to ensure accuracy. These tapes will be used to prepare written
transcripts which will be content analysed.

6.3 Is there any possibility that information of a personal nature could be revealed to persons not directly connected with this project ? [x] N [ ] Y

If you answered **YES**, provide details.

6.4 (a) How will the results of the study be disseminated ?

A report will be submitted to Corrections Health Service. Karolyn White will publish the results as a PhD thesis. It is anticipated that results will be also be disseminated in conference presentations and peer-reviewed academic journal articles.

(b) How will the confidentiality of data collected/disseminated, including the identity of subjects, be ensured ?

Participants and other individuals will be identified by code numbers, not by names. Names of Corrections Health Service and Department of Corrective Service employees which may be mentioned by participants will be replaced by a job description code. Any patient's names referred to will replaced by an arbitrary code.

(c) What is the proposed storage of, and access to, files, audiotapes etc during the study?

Materials will be stored in a locked filing cabinet in K. White's University office, currently A3.02 on the Mallett St campus of The University of Sydney. Access will only be by Karolyn White and Robert Heard.

(d) Specify how long the data files/audiotapes will be retained after the study and how they will be disposed of.

Five years from the completion of the study and then tapes destroyed and transcripts shredded.

SECTION 7: SUBJECT INFORMATION AND CONSENT

7.1 Will a Subject Information Statement be provided ? [x] Y [ ] N

If you answered **NO**, give reasons.

7.2 Will written consent be obtained ? [x] Y [ ] N

If you answered **NO**, give reasons.

7.3 In the case of subjects for whom English is a second language, will arrangements be made to ensure comprehension of the Subject Information Statement and Consent Form ? [ ] Y [x] N

If you answered **NO**, give reasons. If you answered **YES**, what arrangements have been made ?

It is expected that all participants will be fluent English speakers.

7.4 (a) Do the Subject Information Statement and Consent Form :

- give the title of the project on every page ? (Use a short title as appropriate) [x] Y [ ] N
- are the page numbers expressed as page 1 of .., 2 of .., 3 of .. etc ? [x] Y [ ] N
- include an assurance that participation is voluntary and subjects are permitted to withdraw from the project at any time without penalty or prejudice ? [x] Y [ ] N
- give the name and telephone number of an appropriate investigator ? [x] Y [ ] N
- give a telephone number for an Executive Officer of the IEC, should a subject wish to make a complaint about the conduct of the research project ? [x] Y [ ] N

If you answered **NO** to any of the above, give reasons.

(b) Are the first page of the Subject Information Statement and Consent Form printed on appropriate institutional letterhead ? [X] Y [ ] N

SECTION 8: DESCRIPTION OF PROJECT

8.1 Describe the project in lay terms including the aims, hypotheses, potential significance and research plan (including inclusion/exclusion criteria, where relevant). You must satisfy the IEC that the study is valid and in accordance with accepted principles governing research involving humans. Where relevant, provide the projected number, sex and age range of subjects. The description must be no longer than 2 pages and must be in a font size of at least 10 points.

The professional experiences of nurses and doctors who work in correctional environments are under represented in the academic literature, particularly on ethical issues facing health care clinicians. Corrections Health Service also lacks systematic research-based evidence about ethical issues which commonly face their staff. ICAC (1998) recommends that identifying and understanding the prevailing ethical culture in an organisation is an important prerequisite for ethical development. This evidence is also required to assist planning of education and staff support. The proposed project aims to reduce these deficiencies in existing knowledge.

A literature search has found only one article concerning factors influencing nursing practice in Australian prisons (Doyle, 1999), and none dealing with factors influencing the experiences of doctors. Doyle did not focus specifically on ethical issues, though he did identify ethical dilemmas and ethical conflicts as being factors which could influence nursing practice in Australian prisons. Because of the paucity of previous research we propose to take a descriptive approach in the present study to gather basic information about the nature of ethical issues confronting Corrections Health Service personnel.

We will use interviews as the data collection device. Questionnaires are often quicker, and permit anonymity of respondents, but are useful only in situations where enough knowledge exists to permit the framing of appropriate and relevant questions. Interviews are more useful in situations, such as this one, where existing knowledge is too sparse to permit the framing of appropriate questions.

Sampling: Twenty five registered nurses and 10 doctors are currently employed by Corrections Health Service in NSW women's prisons. We intend to take a random sample from this pool. The sample size is guided by two considerations. The first is to ensure an adequate pool of accounts from which to generalise conclusions. The second is to ensure verification of possible effects of profession on ethical dilemmas by having at least 3 people in each profession strata at each Correctional Centre.

Method: Potential participants will be provided with the Subject Information Statement and Consent Form by one doctor and one nurse employed by Corrections Health Service. Potential participants will be invited to contact the principal researcher. Those who agree will be scheduled to attend an individual interview at a convenient time. The interviews will be semi structured. Participants will be encouraged to describe experiences in their work for Corrections Health Service which have posed ethical issues for them. They will be asked to describe two events: one which was satisfactorily resolved and one which was not satisfactorily resolved. They will be asked to describe particular events because we believe this is the best way to gather concrete information which will constitute a good sample of typical ethical dilemmas. An interview guide (attached) will be used. The purpose of the guide is to ensure that all desired topics are covered. It will not be rigidly followed if participants spontaneously mention the critical issues.

Analysis: Interviews will be audio tape recorded. The recordings will be transcribed. Participants will be identified by a number code, not by their names. Any personal names used by participants to denote colleagues or patients will be transcribed as description codes. The transcripts will be content analysed to identify common themes, which will form the basis of a classification scheme for ethical dilemmas and their resolution.

Dissemination: A report will be prepared for Corrections Health Service. This report may inform the updating of policies, and staff development and education of new staff regarding ethical issues. The information in the report will also be relevant to the accreditation process, specifically standard 2.2, *Patient/consumer rights, responsibilities and ethical issues.* As a courtesy, the report will also be made available to the NSW Department of Corrective Service, whose personnel work in close co-operation with staff of Corrections Health Service. A summary of the report will be made available to all interested Corrections Health Service staff. Data from the study will be offered as a paper at the Corrections Health Service Annual Nurses Conference. At least one article will be prepared for submission to a peer-reviewed academic journal.

References:

Doyle, J. (1999). A qualitative study of factors influencing psychiatric nursing practice in Australian prisons. *Perspective in Psychiatric Care*, 35, p 29.

Zipparo, L. (1998) *Ethics: the Key to Good Management,* NSW Independent Commission Against Corruption. Available:http://www.icac.nsw.gov.au

DECLARATION OF RESEARCHERS

I/we apply for approval to conduct the research. If approval is granted, it will be undertaken in accordance with this application and other relevant laws, regulations and guidelines.

Signature of Chief Investigator or Supervisor

Name ..... Signature: ..... Date:

Signature of Associate Investigator(s) or Student(s)

Name ..... Signature: ..... Date:

After careful consideration and appropriate consultation, I am satisfied that the scientific merit of this work justifies its being performed and that the information which will be obtained justifies the inconvenience, discomfort and risks to subjects.

Signature of appropriate senior officer NOT ASSOCIATED with the research (e.g. Head of School / Department / Unit / Dean of Faculty) .

Name:.....
(print)

Title:.....
(print)

Position:.....
(print)

Signature: .....

Date: .....

9 March, 2001

FAXED

Corrections HEALTH Service

Ms Karolyn White
Faculty of Nursing The University of Sydney
Cumberland Campus East Street
Lidcombe NSW 2141

Dear MS White,

Re: Exploration of Ethical Dilemmas and Issues faced by Nurses and Doctors Working in Female Correctional Centers in NSW

Thank you for your proposal, which was considered and approved by the CHS Human Resource Ethics Committee out of session.

However, the Committee would like to remind you that while the ethical side of the research satisfied the Committee the conduct of the study depends on Corrections Health Service cooperation.

It would be appreciated that a progress report on a reasonably regular basis and a final report upon completion is provided to the Committee.

Please do not hesitate to contact me if you require further Information.
Yours sincerely,

Dr Sandra Egger Chairperson HREC

Achieving Excellence in HealthCare

~~corrections Health Service

30 August 2002

Dr Robert Heard University of Sydney
School of Behavioural and Community Health Sciences
P 0 Box 170
LIDCOMBE N5W 1825
Ref: GEN374/QO

Dear Dr Heard

Re: **Changes to Research Proposal "Exploration of ethical dilemmas and issues faced by nurses and doctors working in female correctional centres in NSW"**

The Corrections Health Service Human Research Ethics Committee at a meeting held 20 June **2002** considered and approved your proposed changes to the research project mentioned above.

Please do not hesitate to contact me on 9289 2918 if you require further assistance.
Yours sincerely

~~Dr Sandra Egger Chairperson

FAXED 30/8/02

07/10 2008 11:08 FAX +61 2 90369310 ETHICS UNIT
(a 007/003



The University of Sydney Room K4.01 Main Quad A14
Sydney 2006

Ms K White
Faculty of Nursing
MO2

04 May 2001

Dear Ms White

Your recent application titled *Exploration of ethical dilemmas and issues faced by nurses and doctors working in female correctional centres in NSW* was considered by the Ethics Manager on 20/Q4/01, and in doing so acknowledges your final approval from the Corrections Health Service *Research* Ethics Committee.

Your right to proceed under their authority has been noted.

The University insurers together with Risk Management has agreed that this notification will satisfy the requirements in order far the University to assume liability for the research.
Yours sincerely,

Ms G Briody

Manager of Ethics & Biosafety Administration

The University of Sydney

2 December 2002

Dr R Heard
Department of Family & Community Nursing
Faculty of Nursing
Mallett Street Campus M02

Dear Dr Heard
Title: *Exploration of ethical dilemmas and issues faced by nurses and doctors working in female correctional centres in NSW*

Thank you for your correspondence dated *15 November 2002. After* considering your request to modify your application, it was the Committee's opinion that there were no ethical objections to this work being carried out and therefore recommends approval to proceed.

The following variations were approved:

- Converting the current research project to Ms White's PhD project.
- Dissemination of the results via a PhD thesis as well as in a report to Health Services and through peer reviewed journals.
- Change of Chief Investigator to Dr R Heard
- Change of Ms White to Student Investigator
- Modified Participant Information Sheet

The additional information will be filed with your application.

In order to comply with the National *Statement on Ethical Conduct in Research Involving Humans*, and in line with the Human Research Ethics Committee requirements the Chief Investigator's responsibility is to ensure that:

The individual researcher's protocol complies with the final and Committee approved
1) Modifications to the protocol cannot proceed until such approval is obtained *in* writing.
2) The confidentiality and anonymity of all research *subjects is* maintained at all times, except as required by law.

3) All research subjects are provided with a Participant Information Sheet and Consent Form, unless otherwise agreed by the Committee.
4) The Participant Information Sheet and Consent Form are to be on University of Sydney letterhead and include the full title of the research project end telephone contacts for the researchers, unless otherwise agreed by the Committee.
5) The following statement appears on the bottom of the Subject Information Sheet. Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics Administration, University, of Sydney, on (0.2) 9351 4811.
6) The standard University policy concerning storage of data and tapes should be followed. While temporary storage of data or capes at the researcher's home or an off-campus site is acceptable during the active transcription phase of the project, permanent storage should be at a secure, University controlled site for a minimum of five years.
7) A progress report is provided by the end of each year, Failure to do so will lead to withdrawal of the approval of the research protocol and re-application to the Committee must occur before recommencing.
8) A report and a copy of the published material are provided at the end of the Project,

Yours sincerely



Associate Professor Stewart Kellie

Chairman, Human Research Ethics Committee

Appendix B: Printed Material Given to Participants

The University of Sydney
Faculty of Nursing
DEPARTMENT of FAMILY & COMMUNITY NURSING

SUBJECT INFORMATION STATEMENT

Title: Exploration of Ethical Dilemmas and Issues faced by Nurses and Doctors in Female Correctional Centres in NSW

You are invited to participate in a study to investigate ethical dilemmas and issues faced by nurses and doctors working in female Correctional Centres in NSW. We hope to gather basic information about the nature of ethical issues confronting Corrections Health Services personnel. You were selected as a possible participant in this study because of your employment as a doctor or a registered nurse by Corrections Health Services.

If you decide to participate Ms Karolyn White, Lecturer in the Faculty of Nursing, The University of Sydney, will ask you to describe two events which occurred during your employment with Corrections Health Services and which raised ethical questions for you or your colleagues. She will ask you various questions about these two events. The purpose of these questions is to gather information about the common ethical issues experienced by health care professionals in your work. The focus is solely on the **ethical issues and experiences** of professional staff, not on the professional practice of any individual.

If discussion of these issues causes you any distress you can terminate the interview at any time. Although we do not expect discussion of ethical issues to cause you distress, we have arranged for counselling services to be available should you wish to use them.

Whatever you tell Karolyn White will be treated as strictly confidential and will be disclosed as your information only with your permission or as required by law. The only other people who will see a transcript of your interview will be Dr Robert Heard, Senior Lecturer in the Faculty of Health Sciences, The University of Sydney, and Dr Damian Grace, Senior Lecturer in the School of Social Work, the University of NSW. The transcript they see will have the names of any individuals replaced by codes. Be assured that all records will be stored in locked premises at The University of Sydney, and will be handled only by Karolyn White, Robert Heard and Damian Grace. Under their ethical obligations as University of Sydney and University of NSW researchers they are obliged **not** to reveal any information to Corrections Health Services or Corrective Services which may identify any individuals. While some of the

researchers on the project are Corrections Health Services staff, they will not have access to these records.

If you decide to participate Karolyn White will interview you. This interview will take about an hour and will be audiotape recorded. Karolyn White will transcribe the interviews and replace **any names** mentioned with a code, including yours. She will content analyse the information around the themes of common ethical issues.

Your decision whether or not to participate will not prejudice your future relations with Corrections Health Services.

The results will be summarised as a report and submitted to Corrections Health Services to assist them in workplace education, staff development and possibly the accreditation process. Karolyn White will also write and submit the study as a PhD thesis, under the supervision of Drs Heard and Grace. The results will be submitted for publication to peer reviewed academic journals and possibly at conferences. In any publication information will be provided in such a way that you cannot be identified.

If you have any queries about this project please contact:

Karolyn White	(02) 9351 0581
	Email kwhite@nursing.usyd.edu.au
Robert Heard	(02) 9351 9498
	Email R.Heard@cchs.usyd.edu.au
Damian Grace	(02) 9385 1010
	Email D.Grace@unsw.edu.au

Complaints should be directed to the
Manager, Ethics Administration,
The University of Sydney
93514811

The University of Sydney
Faculty of Nursing
Department of Family & Community Nursing

CONSENT FORM

Title: Exploration of Ethical Dilemmas and Issues faced by Nurses and Doctors in Female Correctional Centres in NSW

You are making a decision whether or not to participate. Your signature indicates that, having read the information provided in the subject information statement, you have decided to participate.

Signature of subject

Please PRINT name

Date

Signature of investigator

Please PRINT name

REVOCATION OF CONSENT

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described in the subject information statement and understand that such a withdrawal **WILL NOT** jeopardise any treatment or my relationship with Corrections Health Services.

Signature

Please PRINT Name

The section for Revocation of Consent should be forwarded to Karolyn White.

Appendix C: Interview Questions

1. Would you mind if I audio-taped this interview?
2. What is your occupation?
3. How long have you practiced as a nurse/doctor?
4. How long have you worked for CHS?
5. Describe how you first learnt about the ethical values/principles necessary for health care practice
6. What do you now see as the ethical values/principles relevant to your practice?
7. Do you think you face any different ethical issues working in the prison context?
8. I would like you to think about a common or routine event which has occurred in the course of your professional duties and was resolved to your satisfaction and explain it to me.
9. I would like you to think about a common or routine event which has occurred in the course of your professional duties and involved an unsatisfactory resolution and explain it to me.
10. Are there any other issues you would like to talk to me about?