Horizons revealed:

Post anaesthetic nurse care for prisoner-patients

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Submitted in fulfillment of the requirements for the degree of

Doctor of Philosophy

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I certify that this thesis entitled

Horizons revealed:

Post anaesthetic nurse care for prisoner-patients

is the result of my own work and that where reference is made to the work of others, due acknowledgement is given.

I also certify that any material in the thesis which has been accepted for a degree or diploma by any other institution is identified in the text.

Full Name:

Signed:

Date:
Acknowledgements

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Abstract

Title: Horizons revealed: Post anaesthetic nurse care for prisoner-patients

For this phenomenological study I used researcher journalling, two audio-taped in-depth interviews and observations of practice of 12 registered nurses, to identify what it was like for them to care for prisoner patients in an acute care perioperative setting. The philosophy of understanding espoused by German philosopher Hans Georg Gadamer was used to draw out the participants prejudices (their verbalisations of their experiences); and their horizons (summations about what the participants expressed); to develop fused horizons (understandings that conveyed the essence of caring for prisoner patients from the participants’ fused and unique perspectives).

Through analysis five key fused horizons or joint understandings emerged that resonated for all participants. These fused horizons were drawn together to develop a succinct statement that expressed the phenomenon of Registered Nurse care of prisoner-patients, which were:

Caring for prisoner patients is an emotion**ally draining experience** where knowing or imagining the prisoner-patient’s crime subtly provokes registered nurses to give reactive and perfunctory care that straddles real and ideal caring perspectives.
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Chapter One:

Introduction
In this study, I explored the experiences of 12 registered nurses who worked in a post-anaesthetic care unit of a large public hospital in Australia, which provided surgical services to the prison population of the state. To achieve the study aim – developing insight into the care experience of nurses caring for prisoner-patients – I adopted a Gadamerian hermeneutic phenomenological approach. In this chapter, I explore the background of the study and the significance of the project, before giving a general overview of the structure of the thesis.

Background to the study

Many years ago, I was in a public setting with a nursing colleague when we encountered one of her patients from the drug and alcohol clinic where she was employed. This man expressed he needed surgery but was reluctant to attend hospital as he was concerned about how he would be perceived and treated while he was there. He previously had negative experiences with nurses, who he believed judged him and consequently withheld care. I found myself thinking of this man often and was surprised on reflection to acknowledge similarities in his experience to aspects of my own care. In particular, I noticed that my nursing care of prisoner-patients differed from the care I gave other patients. For example, I felt I interacted with these patients less on a personal level, spent less time chatting about general things, less time sitting by the bedside, and was overall far more task-oriented in my care. Some factors that contributed to these responses were inherent to the prisoner status, such as the presence of guards and handcuffs, yet others such as spending less time at the bedside and having concerns about drug-seeking behaviour, appeared more complex in their origins. Hence, following the lead provided by Smyth and Holian (1999) who suggested that we research what we are curious about, I embarked on this study.

I have ten years experience working as an educator in the perioperative environment and considerable first-hand experience of the phenomenon under investigation. What I found intriguing about caring for prisoner-patients was that my fellow nursing colleagues when asked, believed the care they gave prisoner-patients was ‘no different’ from the care they gave any other patient. Anecdotally, colleagues expressed it was important to adopt a non-judgemental attitude when caring for prisoner-patients. Also they expressed that being seen as fair was important to them. In fact, they were convinced that they were treating all patients the same. I had some doubts about whether we, as nurses treated all patients
equally and I was interested to explore what might evolve from discussions with my colleagues if more consideration was given to the issue. From my initial curiosity, which developed into this research project, I sought to delve deeper into the convention and expectations of what nurses think we should feel and do when caring for prisoner-patients and to gain some understanding of what we actually do.

The study aims

The aims of the study were threefold. To:

1. Develop in-depth insight into the caring dynamic between registered nurses and prisoner-patients.

2. Examine how caring is enacted by registered nurses in a complex and highly charged emotional setting.

3. Identify coping strategies registered nurses used while caring for prisoner-patients.

Significance of the study

There is a growing body of literature of experience of nursing prisoner-patients from a forensic perspective but there has been little examination to date of the unique circumstances that are experienced by registered nurses when a prisoner-patient presents to a general hospital, where the primary goal is care, not custody. What is known is mostly anecdotal. Discussion in the literature on care and caring is extensive and diverse, yet what is scantily reported is attention to the sometimes difficult experience of caring within vexatious contexts. Discourses on caring focus in the main on the ideals of caring; with little attention being paid to whether these caring ideals are hard to achieve.

Although this research offers insights into caring within the context of a nurse–prisoner relationship; the findings may be applicable in other circumstances where the nurse feels under pressure to care, or in a situation where nurses may have little empathy. To date there is limited literature that explores situations where it might not be in a nurse’s best interest to care in the way that is generally regarded as acceptable practice. There is also a dearth of information available regarding skills required to enable a nurse to care in the diverse situations that may present in their practice and the coping mechanisms that are developed by nurses within
these environments. The focus of this thesis is on the impact caring for prisoner-patients has on the nurse and the ways in which the nurse manages a situation where caring may be challenging and may not come naturally. It is not my intention to pre-empt the study findings and suggest that all prisoner–nurse interactions are challenging or even challenging in the same way. However, in my experience these encounters are different, and the difference served initially as the impetus for this study. The benefit of understanding the impact of this experience is the development of a greater understanding of the complexities of caring and the nursing role.

**Contextual features of the study**

I gave careful consideration to a number of issues that could influence the context of the study either directly or indirectly. The choices I made in the selection of the research design were to foster a climate of mutual respect between the participants and myself and to create openness for dialogue to occur that would enhance understanding of the phenomenon being explored. After much thought, I selected the philosophical framework of Gadamerian hermeneutic phenomenology to guide the study. From the outset, I was aware that I would be conducting research in my own environment, my backyard, and that it would be impossible to rid my mind of the background of understanding that led me to consider this topic worthy of research in the first instance. I therefore selected a philosophical framework that enabled my voice to be heard, yet at the same time facilitated a deep and rich exposition of the participants’ voices. By using a Gadamerian methodological approach, I acknowledged myself as central to the process and commenced a journey of understanding as a joint process between myself and the participants. I strove to ensure the methodological assumptions embedded in a Gadamerian hermeneutic approach permeated all aspects of the study and was therefore used as more than an abstract concept.

To be consistent with the methodology, I elected to write in the first person singular. To do otherwise would be an attempt to portray objectivity and a style of interpretation at odds with a Gadamerian–based approach to understanding. I also thought deeply about issues of consent, for both the participant and the prisoner-patient, holding absolute the desire to do no harm and yet remain aware of the vulnerabilities inherent in both groups. I believe the research decisions I made
were ethical and enabled significant information to emerge that will be of benefit to those engaged in the caring profession.

In keeping with the academic requirements of Deakin University, I use non-sexist language throughout this work, except in instances where I directly quote or refer to the work of another or to a study participant whose gender was known. Therefore, in keeping with Deakin University policy I use the singular plural word ‘they’ or ‘their’ where others may use his/her. Additionally, as the study was undertaken in Australia, I have used Australian English, except in instances where I quote the work of others who utilise different English conventions. Further, to fulfill the requirements of the School of Nursing and Midwifery at Deakin University, I adopted conventions cited within the fifth edition of the Publication Manual of the American Psychological Association throughout this work.

**Assumptions underpinning the conduct of the research**

It was a premise of my understanding that the forensic setting is a fundamentally different environment in which to care for a prisoner-patient than a general public hospital. My sentiment echoed that expressed by Walsh (2005), who wrote that primarily the culture of a prison setting is vastly different to the culture experienced in a hospital environment. Moreover, nurses who choose to work in a forensic and correctional health environment make choices about their care and the environment in which that care is enacted; these are not the same choices as made by nurses working in acute general settings. For example; nurses who select to work in a forensic environment generally have considered fundamental ethical and philosophical questions posed about working in this setting and how it might influence the nature of their nursing care. While dilemmas posed by the custody versus care debate may not be fully resolved to the nurses satisfaction, on some level forensic nurses have considered the dynamics of their care and the influence prisoner-patients have on the delivery of that care. This experience is quite different from those faced by registered nurses who work in an acute care environment and episodically care for prisoner-patients, which is the day-to-day reality of the participants of this research. Fundamentally, this research strove to penetrate the lived world of registered nurses who care for prisoner-patients in a non-forensic setting, to identify how this enactment of the caring role might differ from that of registered nurses delivering main stream care.
The environment in which the research took place

In 1875, religious nuns were asked to journey to Australia, primarily to address the needs of female prisoners in the colony. The hospital where the research took place has a similar religious mandate, and has long cared for the needs of prisoners as well as the general public. The values of the hospital are compassion, dignity, justice, excellence and unity and are as integral to the hospital structure today as they were at its opening in the late 1800s. The hospital has 850 beds and employs over 2000 nurses. It has always provided medical and surgical services to prisoners, and since 1970 has had an eight-bed secure ward dedicated to care for prisoner-patients. The operating suite consists of 10 operating rooms and a 16-bay post anaesthetic care unit. Surgical procedures are performed on approximately 40,000 patients annually; of these 350–400 are prisoners.

All prisoner-patients are allocated a predetermined security rating, which identifies the level of supervision they require when leaving the prison or the secure ward to receive care in other parts of the hospital or community. Most commonly, the prisoner-patient arrives in the operating suite with two armed security guards from a private security company subcontracted for the purpose. These guards wait outside the operating room during surgery and re-join the prisoner-patient in the recovery area. However, some prisoner-patients can be accompanied by six to eight federal police wearing guns on their hips and legs, and two additional police stationed at every exit, and police present in the operating room throughout the procedure. In addition, police teams are stationed in the air and on the ground outside the hospital building. While other hospitals have occasional prisoner-patients on general wards with prison guards in attendance, the service provided by this hospital concentrates this exposure to nurses in a unique way, which made the dynamic of caring for prisoner-patients an ideal one to study.

Terminology used in the thesis

‘Perioperative nursing’ is a general term, however, in Australia the operating theatre nurse, in particular in major metropolitan hospitals, undertakes one of two roles. The perioperative nurse’s role is surgical nursing and the peri-anaesthetic nurse’s role which, in addition to assisting with the anaesthetic delivery, encompasses post-anaesthetic (recovery) care of patients. In some parts of the world, one or more of these roles is conducted by non-nursing personnel (McGarvey, Chambers, & Boore, 2000). The Australian perioperative nurses’
group, however, maintains that registered nursing staff are vital to all aspects of perioperative care. Therefore, at the time this research was conducted a full registered nurse staff was the norm for perioperative settings. Many nurses employed in the perioperative setting have undertaken postgraduate studies, specialising in either perioperative or anaesthetic nursing. The participants were all anaesthetic nurses and in this study I focused on their role, in particular patient care in the post-anaesthetic care unit.

Some ambiguity in terminology exists within the literature regarding the nursing of prisoner-patients. For example; within North America, the term 'jail' refers to a short-term facility for housing prisoners on remand or those whose sentence is for less than twelve months. Jails would generally be centrally located within a city. ‘Prison’ however, refers to a facility where prisoners stay for a longer term and these are usually isolated geographically and socially. In the United Kingdom and Australia, it is common to see these terms used interchangeably.

Several descriptions are used relating to nursing care and prisons, including ‘forensic nursing’, ‘forensic psychiatric nursing’, ‘correctional nursing’, ‘correctional health’ and ‘prison nursing’. Variations in the meanings of these terms can be found within the literature. The term ‘forensic nursing’ can assume a psychiatric link (Encinares, McMaster, & McNamee, 2005; Hammer, 2000) and at other times broadens to include general aspects of nursing care (Veal, 2001). In Australia, forensic nursing is seen as a branch of psychiatric nursing (Martin, 2001) and it is in that context that it will be used throughout this writing. Alternative terms are correctional nursing or correctional health (Bachmeier, 2001) or, in the United Kingdom, prison nursing (A. Norman, 1999), which more specifically refers to general nursing or the general health of prisoner-patients. In Australia, general nursing care of prisoner-patients either within a prison environment or in an acute hospital is known as correctional health.

Thesis outline

The second chapter of the thesis presents the literature review. What is written about caring for prisoner-patients presents two quite distinct clusters within the literature; one on the concept of caring as it relates to nursing and humanity, and the other on exploring what is known to date about prisoners, correctional health and issues surrounding custody.
Initially, I consider the notion of caring and discuss care from a broad global perspective, moving increasingly inward to review social and personal caring constructs. The focus of my discussion is confined to professional experiences of care, in particular those of registered nurses for whom the caring experience is considered by many as fundamental to the nursing role. I then move beyond this caring foundation and explore understandings of the continuum of caring. I suggest that a nurse may have many different experiences of care, from care developing naturally and effortlessly, to situations where caring may be perceived as difficult or challenging for the nurse. These non-caring or complex situations have been largely ignored by nursing theorists, however emerging dialogue within this area is explored and gaps within the discussion are highlighted.

Many demographic groups are over-represented in the prison population internationally, for example, prisoners hail from particular ethnic backgrounds and socioeconomic status, and these issues are discussed in-depth. Health related concerns for the prison population are identified such as the high incidence of substance abuse, infectious diseases and mental illness. Once an understanding of the prison population is established, the focus of the literature review moves to the health care of this patient population, with a review of forensic and correctional health literature. The literature review concludes with an examination of nursing theory to date on the nursing care of prisoner-patients.

Chapter Three offers an explanation about the methodological approach that was used to conduct this study, Gadamerian hermeneutic phenomenology. Phenomenology, with its goal of developing ways of understanding, was considered particularly appropriate for this study, as the information sought was an understanding of what the experience was like for nurses who care for prisoners in an acute setting. In this chapter I present phenomenology in a historical context and then outline key Gadamerian concepts such as, understanding, Bildung and fusion of horizons. When Gadamerian philosophy is applied, in this instance to a research inquiry, it places the researcher at the center of the process, enabling understanding to develop concurrently between the participant and the researcher as their horizons meet.

The methods utilised to conduct the research, namely interviews, observation and reflexive journalling are outlined in Chapter Four and were applied as a process to gain understanding. Each method of data collection is discussed and related back
to a Gadamerian framework. The research design and processes are clearly outlined; and include discussion on the sampling and consent process. Ethical issues, both potential and actual, are explored, along with a description of the mechanisms that were in place to address such concerns. The focus of ethical considerations was on the vulnerability of the prisoner-patient and the familiarity of the researcher to the environment, the research topic and participants.

The study findings are outlined in Chapter Five. In keeping with the study methodology, they are presented within the framework of Gadamer’s philosophy of understanding. The participants’ dialogue is offered to outline their prejudices, a key element to achieving understanding. Prejudices are supported by excerpts of the participants’ dialogue, so that the process of identifying them is clear to the reader. The participants’ prejudices were used to develop each participant’s horizons, or understandings of the complex phenomenon of caring for prisoner-patients within an acute care perioperative setting.

Finally, the participant’s horizons were interwoven to convey a shared meaning of the experience, which Gadamer referred to as fused horizons. Fused horizons are experiences that resonated across the dialogue of all the participants. From the fused horizons, a succinct statement was developed to describe the phenomenon of caring for prisoner-patients.

The experience of the participants generated thought-provoking ideas, which are further explored in Chapter Six. The discussion chapter offers insight into registered nurses care of prisoner-patients; for example, some participants identified the significance of touch or its absence in the delivery of nursing care, an area where their care of prisoner-patients was different to that of other patients. Finally, Chapter Seven draws conclusions about the study outcomes and the significance of the study findings to the nursing profession is raised.

**Chapter summary**

In this chapter I identified the conceptual framework that guided the conduct of this thesis. My experience with the phenomenon of caring for prisoner-patients and curiosity about many aspects of this care dynamic initiated the research explored in this thesis. From a Gadamerian perspective acknowledging my history and pre-understandings of this phenomenon that I have brought to this research process is the first step towards gaining a greater understanding of the experience of caring
for prisoner-patients. In this chapter I have discussed the significance of this research as a means to further understand the nurse–prisoner-patient relationship, and outlined the contextual features and methodological choices. The assumptions and environment that underpin this research are explored, namely that the experience of caring for prisoner-patients in an acute care environment is fundamentally different to a forensic one. Finally the outline of the thesis was summarised.
Chapter Two:

Literature Review
Introduction

In this chapter, the body of literature that is relevant to the topic selected for the study is identified. I used a variety of search techniques and approaches to accomplish a pertinent review of the literature. Initially, I undertook a computer database search using Proquest, Expanded Academic and CINAHL, utilising search words both singularly and in conjunction, with over thirty total combinations. Key terms included care, health care, perioperative care, post-anaesthetic care, prison, prisoner, jail, inmate, incarcerated, nursing, surgery, anaesthesia, ethics, morals, emotion, emotional intelligence, power and wounded healer. The search yielded 180 articles that related to caring, 120 about prisoners, and 56 on related issues such as ethics and social theory.

These articles provided the opportunity to locate additional references utilising chain-search techniques. The sourcing of books on topics of caring and prisoners from a variety of national libraries added further to the investigation. Networking among peers and colleagues who were aware of my research interest resulted in their forwarding articles and books of interest, for which I am grateful. Finally, I accessed an Internet-based national support and chat group for operating theatre nurses, which provided a source of national and international information on the topic of concern. Through this group, I received valuable advice with regard to distinct differences between nursing patients within prisons and caring for prisoner-patients in an acute care environment. These techniques combined to provide a wealth of information, which enabled me to deeply probe the phenomenon of registered nurses caring for prisoner-patients.

To portray the vast array of information on the concept of care, I developed a conceptual framework within which to present the literature review. I commence with an examination of care from a broad global focus. The notion of care as a social ideal is then presented, which is followed by descriptions of the phenomenon of care from personal perspectives. Critical assessment of the literature continues with an examination of the dynamics of professional care, in particular nursing, and continues with an in-depth examination of literature that is specific to caring or not caring for patients. Given that the research focused on experiences of registered nurses who care for prisoner-patients, literature is unveiled that acknowledges prisoner-patients as a social and cultural group with particular characteristics and specific health care needs. However, there is a dearth of literature that examines
the experience of caring for prisoner-patients and the impact it has on the nurse who works in an acute care environment. Hence, this literature is addressed and, as a point of comparison, the work of several nurse theorists, who highlight the experience of nurses caring for prisoner-patients in the forensic and correctional health environment, is critically examined.

At the outset, it was clear that any discussion on care was complex and has many layers; for example my initial probing found the work of Michael Fine (2007a), an eminent contemporary Australian sociologist, who highlighted interesting contradictions regarding meanings of the words ‘care’ and ‘caring’. His assertion, namely, that care ought to be considered from both positive as well as negative perspectives, is notably absent in much of the nursing discourse on caring. In his description of the phenomenon of care, he makes it abundantly clear that care is “altruistic, positive, and often romanticised” (p. 27). However, he also depicts care as “involving worry, control and self-sacrifice” (p. 30). These contrasting, and indeed somewhat conflicting sentiments, suggest the dual nature of care – that is, one can rightfully assume that to care is a privilege but to care can also be a burden.

Not all authors agree that there is a negative side to care or caring. For instance, Simone Roach (2002) asserted that care is the human mode of being and claimed that “authentic human caring is not subservience, not subordination, not subjection to control but a way of living that fosters human freedom in all relationships” (p. 7). These ideas arguably illustrate the romanticised version of caring that Fine referred to and are certainly in strong contrast to his conception of care as a burden. Further, on deeper examination of Roach’s contention that care is a way of living; a question is raised regarding whether this view can be applied in all situations, most notably in the nurse–patient relationship in the context of caring for ‘difficult’ patients, which is the subject of this research.

What is highlighted within the caring literature is that caring is a complex phenomenon that warrants further consideration from a contemporary perspective. The increasingly honed focus of care from a global perspective to the salient discussions on caring for prisoner-patients is the path of this discussion. It is important to elucidate how literature on caring addresses complex needs of prisoner-patients and registered nurses who care for these patients, which will be
shortly discussed. Next presented is a brief synopsis of the emergence of the phenomenon of global care.

**Global care**

Increasing attention has been paid in the literature to subtle yet pervasive shifts in our gaze from care as a private matter to care as a public concern (Fine, 2007a; Noddings, 2005). In this chapter, I use the term ‘global care’ to describe a growing phenomenon or expectation whereby care or caring is transferred from individuals to the global community. The complex needs of the environment, threats to endangered species, natural disasters and the experiences of world-wide poverty and starvation attest to the reality that there are world-wide concerns we should care about today (Johnson, 2005; Wilson & Law, 2007). Evidence abounds that suggests that over the last several decades care organisations have emerged and are providing care on a global level. There are numerous forces at work that have made the provision of global care a reality in recent years, such as improved transport facilities that can swiftly move both people and resources to areas where they are needed. Also advanced communication technologies which, together with the media, draw attention to the plight of those in need following catastrophic events such as famine and war, make these world issues real and compelling, increasing our global consciousness.

An expression of global care was exemplified by the response to the 12th January 2010 Haiti earthquake. Many thousands of people died or became homeless in this catastrophic event. US President, Barack Obama, described the type of assistance his country would deliver to the Haitian people, suggesting that “we do this because we care” (Obama, 2010b, unpaged). The American aid response was referred to as a “mobilization of the compassion of the American people” (Obama, 2010a, unpaged) which reminds us, President Obama suggested, of the common humanity that we all share. The best and worst of our humanity is exemplified within the experiences of global care, in that it clearly identifies situations where people mobilise to care in situations where care is inadequate. A catastrophe on a large scale can also typify the worst humanity has to offer, as seen with looting in disaster zones. The response to the Haiti disaster was met not only by the United States of America, but also by many international aid organisations such as the United Nations, Red Cross and World Vision. These organisations, among others, act as an intermediary so that those individuals who want to demonstrate care to
those in need are able to do so, even if those in need are significantly removed from their everyday experiences. The opportunity exists for financial contributions to be made and transformed into real and practical assistance where needed. Noddings (1990, 2005) described this type of care as caring-in-chains when she wrote about an emotional connection where an intention to care is passed through social networks. For example, if I am unable to physically go to another country and care for starving children, I could give money to someone I trust, to pass it on to someone they trust and so on, until the money is delivered to someone who can act and feed the children. When considering care on a global scale, the dynamics of caring may be enacted differently from a more personal experience, but the intention to care remains.

It has been suggested that, in the absence of global citizenship, reciprocity between those who need care and those who can give care is missing (Como, 2007; Noddings, 2005; Postma, 2006). Without a connection or a personal emotional attachment, people find it difficult to care. It is the need for attachment that World Vision, among others, attempts to address with the child sponsorship concept. While it is not always feasible for care on a global scale to be grounded in interpersonal relationships, Cassidy (2005) and Noddings (2005) suggest we should attempt to foster emotional attachments for others in the world whose needs are clearly tremendous. Perhaps people do care about the world environment and about the countries with starving populations, but the hurdle is transitioning this care into action.

Examples of transition to action can be seen by philanthropic humane endeavours such as those of Sir Bob Geldof and Midge Ure who coordinated Live Aid, a live music event aimed at generating funds for the Ethiopian famine, in 1985. This event raised 283.6 million dollars through ticket and record sales (retrieved 31 December, 2009 from http://www.herald.co.uk/local_info/live_aid). Actor George Clooney mirrored these endeavours, by organising a telethon, an international event that hoped to raise in excess of 100 million dollars for the victims of the Haiti earthquake (Goddard, 2010). Charlie Simpson, a seven-year-old British boy, organised a bike ride around his local park for the victims of Haiti and raised $240,000 (retrieved 26 January, 2010 from http://www.foxnews.com); highlighting that celebrity is not a necessity for action. An issue identified with global care is that an individual may feel as if their efforts will make little difference to the environment, people or animals in need. Live Aid, the Haiti telethon and Charlie
Simpson demonstrated the difference a few individuals could make. These individuals transitioned their concerns for the needs of others into action and increased awareness through the publicity generated by the events, which highlights the potential of an individual’s capacity to care. Each of these examples illustrates global care in action. Unique to the organisations and individuals I have identified as examples is a belief that the effects of global issues, such as hunger, famine, poor sanitation and poor health, can be ameliorated.

While it can be seen from previous discussion that global care clearly exists, a question can be legitimately raised regarding whether the provision of global care is enough, both in terms of quantity and quality. Another question that is raised is whether individual responsibility is supplanted by global care initiatives? Pondering these issues and the overwhelming realities of those who need care raises a question about why we do not do more or care more. I contend, as do a number of others, that despite those working hard to address areas of need, we are not yet meeting the global care needs of the world we live in. When searching for answers, it has been suggested that many global issues are somewhat removed from the everyday experiences in which most of us live. Another possibility that our emotions are dulled by the media’s overexposure to catastrophic events, hence for some, the impetus to care is missing.

There is, some suggest, a separation from the natural world caused by an industrialised, consumer-driven society which makes it difficult for people to feel connected to and care about the planet that sustains us (O'Brien, 2007; Postma, 2006). Riseman (1997) and Herdman (2004) considered that we live in a post-emotional society, where it is the norm to separate emotions from actions. In a post-emotional society, people do not react to situations and crises in the world in the same way as they would have in the past and their emotions are blunted. As a result, people become blasé about events in our world such as poverty and natural disasters and, as Riseman suggested, there is little empathy for the global issues affecting them. If one explores the care dynamic through a lens of action, attitude, motivation and relationship, which is the lens that I used when engaged in my study, I suggest that one of these dynamics may be missing or obscured, particularly in situations where care may be difficult to enact. Or, as Shei (2005) suggested, if people do not feel morally responsible, they are removed from the need to care.
Patrick Boylen-Fitzgerald (2003) provided insights into the concept of care through his descriptions of compassion and pity (fearful pity and aloof pity). He identified care as an act of pity seen as feeling sorry for, starving millions for example. Pity implies an emotional distance, where there is an element of sympathy but no real call to action. The second type of care was compassion, or feeling sorry with someone for his or her situation, in a manner that requires some kind of response. Both pity and compassion are forms of caring, in that it is not just that people should care; they need to care with action. In this sense, compassion is caring with action and pity is caring without action. Compassion moves past a need for a personal connection on which to base a caring relationship, and yet it is founded on an emotional connection.

Through this discussion, it can be seen that there is a need for global care. However, this type of care does not obviate the need for other forms such as personal and professional care, which will shortly be discussed. Issues of care, caring, caring for and caring about are inextricably linked and refer to a need and drive within human society to care for others. Next, I will discuss the concept of social care, where I argue that care is a social issue and which Fine (2007b) asserts is an essential feature of social life.

**Social care**

Many believe that the need to be cared for is a universal human need. We are born absolutely dependent on others for care; we all need to be cared for at some time or another in our lives. Engster (2005) eloquently postulated that, we “live in a web of dependency and caring” (p. 61). As we grow, we are (potentially) in a position to reciprocate this care by caring for others in our society and society relies on this responsibility. A caring society is one in which we serve the needs of others by our concern (Griffiths, 2008). A striking example of society’s response to the need for care arose in Australia in the year 2009 when bushfires raged through the townships of Marysville, Kinglake, Glenburn, Kilmore and Flowerdale, all located in the north and east sectors of Victoria. During this firestorm 173 lives were lost and over 2000 homes were destroyed and 7,562 people were displaced (Gray, 2009; Gregory & Dobbin, 2009). Of particular significance was the eradication of the township of Marysville, regarded as a popular tourist destination. In the aftermath of the fire, the Australian people rallied to a call to provide care to those ravaged by the fire, many of whom lost everything, and in total $300 million was donated by
individuals and corporations, with federal and state governments contributing further to the cause of re-establishing these communities.

Within Australia, organisations abound that are specifically dedicated to meeting the needs of the poor, homeless and/or indigent members of society. An example of one such organisation is the Salvation Army, established in Australia in 1880. The Salvation Army works to support the homeless, people suffering from addictions such as gambling and those affected by domestic abuse and, among other things, provides counselling services, accommodation and meals (retrieved 31 December, 2009 from http://www.salvos.org.au/about.us/overview). This organisation embodies care by meeting the needs of those in society who are deemed socially disadvantaged and cannot for whatever reason find the resources needed to care for themselves. Another example of a social care organisation is the Brotherhood of Saint Laurence that is an Australian welfare organisation established during the Great Depression to address poverty and continues today to meet the needs of society’s poor and disadvantaged (retrieved 31 December, 2009 from http://www.bsl.org.au). Like many of the organisations mentioned, the Salvation Army and the Brotherhood of Saint Laurence provide care without prejudice, without the expectation of something in return, and epitomise the caring ideal.

While the discussion has thus far focused on care for people, a number of organisations are specifically dedicated to care for animals and the environment. Examples that illustrate this are the Royal Society for Prevention of Cruelty to Animals (RSPCA), a non-government community-based animal welfare charity with a vision to ensure all animals are free from hunger, discomfort, pain and fear (retrieved 31 December, 2009 from http://www.rspcavic.org.au/about.us) and the Lort Smith Animal Hospital a local animal shelter which cares for stray animals and attempts to reunite them with their owners or re-house them (retrieved 31 December, 2009 from http://www.lortsmith.com/about_us). The Prince Charles charity provides an example of an organisation that cares for the environment. This group of over 20 charities has a focus on protecting and sustaining the natural environment as well as the built environment (urban development to create healthy environments). The contribution to care for animals and the environment from these organisations and others like them should not be dismissed, as they perform a vital role in valuing and contributing to a cycle of care in society. As human beings we are interconnected to the natural world and the degradation of the
environment is to the detriment of people. Anne Boyd (2010) summarised this position well when she suggested “we have seriously lost our way if we are unable to grasp that the so-called economy of markets exists in some ethereal realm of everlasting growth on a finite planet” (p.3). Arguably, I maintain that without this care contribution, our understanding of the imperative to care is incomplete.

Another social aspect pertinent to a discussion on care is that in most developed countries, care has gone ‘public’. That is, the care of children, the elderly and the sick no longer takes place only in the home, unpaid and in private, but over the last century has moved into the public sphere. With the advent of both industrialisation and the women’s movement, care has moved away from being a strictly female domain, invisible and taken for granted in the domestic arena, to become a social expectation that the state will take responsibility for society’s care needs such as childcare and health.

The shift of care to the public arena has resulted in care delivery becoming paid work, and consequently has necessitated the development of human services and the expansion of caring professions such as nursing and social work. This delegation of caretaking has become imperative to the function of most societies, and without it there could be no society – for example orphanages have been created, adoption and fostering strategies are in place in most developed countries of the world, and purpose-built accommodation facilities have been developed to provide care for profoundly disabled members of society. These are but a few examples and there are many more whereby the call on society to meet the needs of its people is met. Fineman (2004) suggested that it is caretaking labour that produces and reproduces society. However, despite the fundamental nature of care delegation and its significance to society’s function, those who participate in care work are undervalued and often underpaid. Having explored the phenomenon of care from global and social perspectives, I now examine aspects of care that influence us as individuals in a uniquely personal way.

**Personal care**

Many would contend that care experiences are fundamentally personal. Heidegger (1962) in his work *Being and time*, laid the ontological foundation of being and its connection with *Sorge* (care). Fundamental to Heidegger’s view of human existence was his emphasis on the connection between our being and our world, believing that humans were inseparable from their world (McConnell-Henry,
Chapman, & Francis, 2009). This connection was manifest, Heidegger asserted, through care, in that everything one does can be understood as a way of caring and, moreover, demonstrates our connection to others. Waterhouse (1981), who elaborated on the work of Heidegger, wrote that “without care nothing matters…” (p. 91) and asserted “care is the Being of Dasein” (p. 70, author's emphasis). Care, therefore, according to Heidegger, is an imperative, essential life experience.

It is important to acknowledge that many authors place discussions of care within a philosophical orientation, notably Mayeroff (1971), a moral philosopher, who claimed that care is a universal phenomenon that is the very essence of human nature. Although various definitions of caring are professed in the literature, the seminal work of Milton Mayeroff offers some insights into this complex phenomenon. Mayeroff espoused that caring is relational and an ontologically based experience. Within his work, Mayeroff identified that caring is not an isolated feeling or a momentary relationship; it is rather a process, which takes place over time and which builds on such qualities as patience, honesty, trust, humility and courage. It is only through caring and being cared for, Mayeroff asserted, that one can find meaning in life and grow and develop into all that one could be.

Another significant contribution to the discourse on caring is that of German philosopher Martin Buber (1878–1965) whose work contributed much to the thinking on care and caring within our society. According to Buber (1958), an individual’s basic connection in the world is an expression of his or her own existence (Cohn, 2001). A central focus of Buber’s writing is about understanding one’s relationship with God, and also the relationship between individuals or nature and how they interact with the world. Buber referred to the I-Thou and the I-It. In an I-Thou relationship, which occurs between two beings who acknowledge mutual existence and see each other for who they really are, an authentic encounter occurs such as that which is evident in a caring relationship (Buber, 1958). Thus, it can be seen that the I-Thou relationship is one of reciprocity (Cohn, 2001). By contrast, an I-It relationship occurs when two people encounter each other but do not connect. Rather, the I objectifies the idea or concept of the other person and does not authentically encounter them in any real way (Buber, 1958). Cohn (2001) suggested that the I-It is not a relationship of reciprocity, but is rather one of domination or control. When one mutually engages with another person, they move from being an objective subject of analysis (It) to a subject with which one has a
relationship \((Thou)\) and it is the relationship that moves the experience to the \(I-Thou\).

Buber considered dialogue between two people as the essence of relationships and it is for this reason that Buber’s thoughts have been so influential in the caring discourse. He developed a theory about the distance between two people (or mankind and God) and how that distance could be bridged, through a process he referred to as crossing over. In any relationship, crossing over may take place and, when it does, it is characterised by the person feeling very close to the other, in a moment of shared meaning (Buber, 1965). Crossing over is variously expressed by other authors; for example, Maatta (2006) who equated it to empathy.

Jean Watson, a renowned nurse theorist, espoused a caring science in which she offered a description of care that embraces both philosophical and scientific attributes grounded in a relational–ontological view that honours people’s unity and interconnectedness. Watson, like Buber, perceived relationships between people as fundamental to humanity. As Watson (2008) explained, “caring science moves humanity closer to a moral community, closer to peaceful relationships with self–other communities–nations, states, other worlds and time” (p. 17). It is the caring relationship which Watson (2005) believed “connotes a spirit-to-spirit connection within a caring moment” (p. 6) and invited the emergence of the human spirit. For a caring relationship to occur, Watson (2005) asserted that intentionality was required; she defined intentionality as “consciousness and awareness that are directed toward a mental object with purpose and efficacy toward action, expectation, belief, volition, and even the unconscious” (p. 191). Watson’s view of intentionality incorporates the noetic and she offered an expanded view of consciousness. Bearing these thoughts in mind, it can be seen that intentionality guides both choice and action and could enable individuals to enter into an \(I-Thou\) relationship. These concepts are important to acknowledge because, as Watson suggested, having an expanded view of consciousness offers theoretically different ways of caring and enacting a caring moment, in which one is mindful of one’s own humanity and that of others.

When I commenced this research, I perceived care to be exemplified in two ways: caring \textbf{for} (the activities of care) and caring \textbf{about} (the attitude of caring). I had given little consideration to the other dimensions of caring that have been outlined by eminent philosophers such as Buber, Mayeroff and Watson. Consequently, after
considering what the personal aspects of care entail, I now recognise a **motivation** to care (thoughts that direct the will to care) and engage in a caring **relationship** (the response from the one cared for). I believe an ideal caring relationship encompasses all aspects, but also consider these aspects can occur on their own or combined at different times, within a caring moment. In light of this, discussion now continues to further critique the concept of personal care.

As was previously stated, we are all born dependent on care. A primary example of this is the maternal experience of care between a mother and child, which is seen as natural care, something instinctive or innate, and considered by many to be the basis of all other care relationships within our society (Fry, 1989; Ruddick, 1989). The significance of maternal care experiences for women gives rise to extensive debate about the innate nature of care and women’s role within the caring discourse. Tronto (1995) suggested that “embedded in our notions of caring we can see some of the deepest dimensions of traditional gender differentiation in our society” (p. 101). Peta Bowden (1997), used a framework of social organisation and power structures to write about caring from four perspectives: mothering, friendship, nursing and citizenship. Bowden considered mothering as an archetype for caring:

> Seen as the functionally necessary and natural realm of affection and love, enduring and unconditional openness, and responsiveness to the particular material, emotional and social needs of another person, mothering frequently carries the full weight of ideological constructions of caring (p. 21).

Bowden considered mothering to be deeply embedded in social institutions like the family, which society and social power structures reinforce. Because women are the focus of maternal care, some suggest there is reason to believe that women are somewhat better equipped for caring than men (Noddings, 1995) or perceive its value more easily, based on the maternal–child experience (Gilligan, 1995). Certainly women are dominant in discussions on caring, but this should not entail a presumption that women are better at caring than men. There are differences between men and women, and the manner by which care is enacted; some of these differences are discussed in the literature on the ethic of care.

Held (2006) stated that “the central focus of the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility” (p. 10). The ethic of care is a theory of moral development that focuses on the feminisation of care. It stems primarily from Carol
Gilligan’s (1982, 1995) seminal work, on differences in the way women and men develop a moral outlook. Gilligan, a developmental psychologist, used Kolberg’s (1981) study as the basis of her work to elaborate on moral development in children, ultimately concluding that when girls are presented with moral problems, they reason in a different way from boys and focus on actual relationships between people. A male approach to moral reasoning is often referred to as a justice ethic, which focuses on individual rights, fairness and equality; Gilligan’s theoretical perspective presented a view that valued caring and referred to this as an ethic of care.

Central to the ethic of care is the view of care primarily as a disposition towards others, a concern for maintaining relationships and nurturing the world around us (Fine, 2007b). In identifying a different moral code based on care, Gilligan established the experience of women as important and relevant and emphasised the importance of care delivery in our society (Jagger, 1995). The ethic of justice and the ethic of care view the world from different perspectives. It could be considered that care is more fundamental than justice because, when people sincerely care about others they find ways to treat them with justice, fairly and equitably (Lin, 1999).

The ethic of care is criticised by some feminists who consider that the feminisation of care merely reinforces stereotypes about both women caring and institutional power structures (Bowden, 2000). Certainly, the theoretical development that recognises the significance of caring within our society stems predominantly from or in response to feminist discourse. The caring ethic is also considered inadequate, as it does not provide definitive answers in cases of conflicting moral demands. What it does do, for better or worse, is explicate the often undervalued, unspoken issues surrounding care and those who participate in care giving. As Fine (2007a) reminded us, the ethic of care is a social issue more than a women’s issue, as some consider that we live in a society that does not value either care or those who work in caring professions (Gastmans, 1999; Reverby, 1987).

Caring is an inclusive human trait that denotes a way of being in the world (Cortis & Kendrick, 2003). Individual experiences and understandings of care are uniquely personal and are influenced, as Gadamer suggested, by the totality of our life experiences, our society and our culture, all of which contribute to the person we are. Both global and social perspectives on care suggest a moral orientation
towards living in the world that drives the care experience (Fine, 2007b). But what is a moral orientation of care? To explore the concept of personal care further, I focus on two significant elements that contribute to our personhood: our morals and virtues, as these states of being are dominant in discourses of care.

Virtue is a state of character, a kind of second nature (Aristotle 384–322 BC). Virtues influence the person we are, and the theoretical basis for virtue ethics is that a good person does a good thing (K. Smith & Godfrey, 2002). Virtuous attributes are many; for example, Saint Paul lists as virtues faith, hope and love (1 Corinthians 13:13). Care is also considered by many as a virtue, because of its close association with love and kindness and because of its innate goodness (Arman & Rehnsfeldt, 2006; Warna-Furu, Lindholm, & Eriksson, 2008). Seeing care as a virtue implies that care is not a natural impulse or feeling but, rather, an attribute that develops with experience (Curzer, 1993; Halwani, 2003).

However, not all care is virtuous and it is the motivation behind a caring action that determines its value (Boleyn-Fitzgerald, 2003). For example, care as pity cannot be seen as virtuous as it remains emotionally distant, whereas compassionate care is virtuous. It is not an expectation that care will be delivered unconditionally on every occasion but, rather, that virtues are revealed in patterns of behaviour over time (Roach, 2002; Tomlinson, 2008). A virtuous person can still be human and flawed, but they strive to do the right thing. Care as a virtue, therefore, refers to a person's caring nature and the motivation to care, rather than a particular caring act, which implies that a person with a caring nature will act in a caring manner.

Morals are the values that influence a person's code of conduct. To define care as a moral value implies that the emotional engagement and the physical activities of caring are seen as good human values and can be used as a framework for making moral choices. Society has a moral obligation to care for others; and caring is seen as a moral imperative. In this way, care is seen by many as a moral value (Cortis & Kendrick, 2003; Cronqvist, Theorell, Burns, & Lutzen, 2004; Gastmans, 1999). Care is just one example of a moral value; others include respect, honesty and integrity.

If care is regarded as a virtue that exemplifies the caring attitude experienced by an individual, care as a moral theory regards care as a basic expectation placed on an individual, by society a requirement to participate in or enact caring behaviours.
The morality of care establishes an objective standard, moving it to a solid activity more than just a virtuous attitude (Held, 2006). What is needed for caring to occur at a personal level are both the desire to care and the activities of care. Care as a moral value places the needs and interests of another person on at least the same level as our own needs, even if it is against our best interests to care (von Dietze & Orb, 2000). For example, both Frankle (1959) and Nesaule (1995) wrote about caring within Nazi concentration camps and made the point that even in the worst times people may not lose the will to care for others. In a sense, a moral theory of care implies that we will care for others unknown to us, not just people for whom we feel affection (Engster, 2005; Slote, 1998). These notions of virtues and morals are not distinct; as Gastmans (1999) suggested, “concrete caregiving actions receive their (moral) significance only from a caring attitude” (p. 219). The two things go hand in hand.

So what is it that makes a caring person or makes a person care? Is being a good person and doing the right thing enough? Virginia Held (1993) maintained that a caring person will not only have the intention to care and the disposition to care effectively, but they will also participate in caring relations. Held highlighted that, if a person lacks the capacity to care, they are trying to be caring, but they are not yet a caring person, which provides food for thought regarding my earlier assertion that caring is embedded in motivation, action, attitude and relationship.

**Professional care**

As previously discussed, the incremental movement of care from the private domain to the public arena resulted in the creation of professional roles that inherently require a degree of emotional input or caring; nurses, teachers and social workers provide examples of this. The implications of a requirement to care in the work environment are described as both complex and elusive (Paley, 2001). Paley attempted to demystify the experience and claimed that further clarification is needed. The caring experience is different at work from at home for many reasons. Caring relations in families are ongoing and caring usually stems from the relationship (Tronto, 1993). In the work setting, caring relationships are limited and more proscribed (Greenleaf, 1991) and the relationship stems from the caring (Tronto, 1993). Scant attention is devoted to considering the emotional or affective dimension of caring within professional relationships. For this reason, I now turn to caring within a professional context. I use the term ‘professional’ here when
referring to the working environment and role, not to depict a certain level of competence or behaviour.

Roach (2002) identified six attributes of professional caring: compassion, competence, confidence, commitment, comportment and conscience. These characteristics are commendable for anyone in a caring profession to embrace; but do they do justice to the notion of care? I assert that these attributes are an ideal position from which caring ought to be seen, and question whether they mirror the reality of caring practice. Listing competence as an attribute of caring, for example, could restrict those not yet competent from being described as fully caring and it may not be reasonable to assert that junior nurses who are not yet competent do not care. Also missing from the description of caring attributes is a thick description of the various contexts and complexity of situations in which caring takes place. Further, it is possible that one or more of the attributes of caring may be absent or restricted by the caring individual and yet this person still cares. For example, in a nursing situation, nurses may be genuinely committed and conduct themselves in a competent, confident and professional manner and yet may hold back on being compassionate. This is an important point to consider, particularly as literature that differentiates care from caring is not always clear.

Other authors have examined Roach’s attributes of professional caring and extend them to include communication, comfort and courage (Wilkes & Wallis, 1998). Aligning an ever-increasing number of attributes with care presents conceptual difficulties, as well as suggests that a professional mandate to care is not enough as care entails a long list of other admirable qualities, perhaps beyond the reach of some. Caring, although extremely important, is just one element that contributes to the ability to enact a professional role.

The concept of caring in relation to emotional involvement or requirements within the professional world initially received attention through the work of Arlie Hochschild (1983), whose seminal work explored the role of care and emotion with flight attendants. Hochschild noted that, at times, there was a gap between what flight attendants felt for passengers on an emotional level and what they thought they should feel or what the company wanted them to feel. She described the effort to bridge the gap between these two positions as emotional labour. An important aspect of emotional labour as discussed by Hochschild (1983), the search for authenticity, involves the individual displaying emotions which not only seem polite
but also, more significantly, appear genuine. Curzer (1993) purported a similar view for professionals, namely, that they should act as though they care, but not necessarily care. This sentiment is very similar to that of Noddings (1984) whose work on ethical caring suggested that the question to be answered when in a situation whereby care does not come naturally is ‘How would I respond if I really cared?’ Noddings’ description of natural caring and ethical caring raises a question regarding what level of care is acceptable within the professional context. Is it acceptable to act as if you care when you may not? In the context of my research, these are vital questions to ask and to consider.

Both internal and external forces have influence on a person’s caring and drive their emotional responses. Personal beliefs and preferences are an example of an internal force, as Roach (2002) suggested, an individual cares, not because of their professional role, but because they are human. External forces such as social constraints or pressure from budgets and policies also play a part in the ability of individuals to care. Tronto (1993) highlighted this when she wrote that bureaucracies often force people to give care in ways they might not personally choose. This leads to the important point that a caring attitude is not found in a vacuum, it is situated within a context (Bubeck, 1995; Gastmans, 1999). For example, teachers may need to choose, due to time constraints, which child is more worthy or would benefit the most from having access to their care. Thus, the choices that those working in the caring professions make may have both a personal impact, on the individual child or patient for example, and significant social impact; that is, “caring professionals have the capacity to affect the lives of everyone in their societies as well as other aspects of the world around them” (Hugman, 2005, p. 39). It is important to have an understanding as a caring professional about how we can maximise the benefits and minimise the negative aspects of professional care.

In this discussion, I proposed that contrasting ideas are offered in the literature regarding the phenomenon of caring in a professional context. On one hand, it is argued that merely going through the motions of a caring activity and doing the work of caring without any of the appropriate feelings or intentions is not caring (Held, 2006). On the other hand, it is claimed that caring as described in the Oxford English Dictionary, and reiterated by Bubeck (1995) does not seem to require any particular emotional bond between the carer and cared for; it is in response to basic human needs and can be seen as a burden. Indeed, as Curzer (1993)
suggested, the expectation on professionals to care is a vice and not always intrinsically desirable. Emotional attachment experienced when caring for patients is problematic, for example, making it more difficult for health care professionals to be objective. Descriptions of nursing as a caring profession dominate the literature on professional caring experiences. Therefore, in the next section of the literature review I focus on nursing to illustrate a professional care context. However, it should be noted that many of the issues highlighted in the following discussion are relevant for other caring professions.

**Nursing and caring**

Arthur Frank (1995) wrote from his perspective as a patient and as an individual had a close collegial relationship with nurses. He considered one of the most difficult challenges for human beings is to listen to the voices of those who suffer, which, he suggested, is a characteristic of nursing. The notion of caring in nursing is not new and most authors would agree it is an implicit element of the profession. However, a definitive definition of the concept is yet to be established (Paley, 2001). Watson (1985) wrote prolifically on caring and nursing and suggested it as the moral ideal. Morse, Bottorff, Anderson, O’Brien and Solberg (1992) agreed, after an extensive literature review, and described caring in addition to a moral ideal as a universal human trait, an interpersonal relationship, therapeutic intervention and an affect. Henderson (2001) offered the view that

> Caring clearly involves feeling, and feeling involves personal vulnerability. The decision of any individual nurse to care for (or emotionally engage with) a client is therefore one which exposes that nurse to the potential for personal costs or benefits as well as professional ones” (p. 131).

The merging of professional and personal boundaries, I contend, may leave a nurse vulnerable, as it is not possible to hide behind a mask and authentically care. This is an important point and one which was considered in the conduct of my research.

Bowden (1997) described caring in nursing as being very different from the freedom found in friendship, because the relationship is usually between strangers and is regulated within social and organisational structures. Bowden’s four expressions of care (mothering, friendship, nursing and citizenship), placed the type of caring found in nursing in a position of importance, particularly because
nurses are in the unusual situation of caring for strangers. Taylor’s (1994) work on nursing and caring, however, suggested otherwise when she stated:

Patients and nurses, who become so close to one another, develop a relationship which is best expressed as a ‘family-like’ tie. Nurses and patients can choose family-like relationships and risk the vulnerability of closeness, because they are not bound necessarily by the confines of a professional relationship, which might demand detachment (p. 227).

I contend, and others agree, that the type of caring found in nursing is a far more structured and socially constrained feeling than that found in friendship or family relationships. It is a professional relationship, as it rarely extends beyond the context in which it was established into the world outside of a nurse’s professional life. It would be far too difficult to expect a nurse to become friends with every stranger whom they encountered as a patient.

The idea of caring as emotional work, as identified by Hochschild (1983) and previously introduced, is also elaborated upon in nursing literature (Bolton, 2000; Bone, 2002; Henderson, 2001; Herdman, 2004). There are several aspects to the embodiment of emotional labour in a nursing context to which attention is now drawn. In the service industry, it is a common organisational expectation that an employee will act in a certain manner. Hochschild considered this a cause for concern because, as the individual loses ownership over what they feel, it results in alienation from their true self. For nurses, concern could arise in situations where a nurse is expected to care, even when the inclination to care is absent. It is interesting to note that, at times, nurses work hard to remain detached from their patients; while at other times they work at engaging or building rapport with patients. Both situations are examples of bridging the gap between what is felt for a patient and what the nurse thinks they should feel; what Hochschild described as emotional labour. The concept of emotional labour is summarised by Bolton (2000) who wrote: “to carry out emotion work is the act of attempting to change an emotion or feeling so that it is appropriate for any given situation” (p. 581). This emotional management is not without personal reward and cost. For many, the satisfaction they get from doing their job well is derived from the personal contact they have with patients (Henderson, 2001), with the effort sometimes required to engage with patients being altruistic and heartfelt (Bolton, 2000).

The relationship between emotional labour and burnout has been described as having negative feelings provoked by failing to enact the type of nursing care
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desired by the nurse, resulting in feelings of inadequacy (Zapf, 2001). Situations whereby nurses find it easier or alternatively more difficult to care for patients are presented in the literature. Baer and Lowery (1987) examined the effect of patient characteristics on whether student nurses liked or disliked their patients, noting that students most preferred caring for persons who were cheerful, communicative, accepting of their illness, and accepting of nursing care. Conversely, patients labelled as difficult by nurses received less care. Given that nurses are taught to care for all patients on an equal basis, Bolton (2000) recommended that they learn to reconcile possible dissonance between caring and not caring through engaging in emotional work or emotional labour. This effort required to develop caring relationships resonated with Noddings’ work on ethical caring which assumes that any type of care is acceptable; it implies that the actions of care are important – the emotions behind it matter less.

Care for and care about

An assumption within nursing culture is that both caring for and caring about patients is intrinsic to the role of the nurse. However, recently this notion came under debate by newly graduated nurses in the United Kingdom. The students suggested that they were too well qualified to care for their patients by attending to their hygiene needs and felt this should be left to care assistants while nurses focused on more technical aspects of care. This ‘too posh to wash’ debate (Bore, 2004; Hooper, 2004) ignited discussion regarding the role of the nurse when caring for and caring about patients. As Hooper (2004) summarised “provision of care, after all, is not just considered a ‘posh’ perk; it is the essence of nursing” (p. 293).

Other authors (Corben, 2008; Wright, 2004) suggested nursing is impoverishing its values with a decreasing emphasis on the practicalities of caring for patients. Wright considered that nurses are being seduced by the more technical, intellectually and practically demanding aspects of nursing care, which are viewed as prestigious and are rewarded within our profession, whereas the more subtle invisible and intuitive aspects such as listening, comforting and helping to cope are considered ‘low level’, too demeaning and undignified for clever nurses. The technical aspects of nursing and taking care of patients has been described in several studies as most important to patients (Greenhalgh, Vanhanen, & Kyngas, 1998) and to student nurses (Bjorkstrom, Johannson, & Athlin, 2006). The activity of care needs to be present as a base for the attitude of caring to develop and it is
noted that an emotional connection without the fundamentals of the activities of nursing care does not meet the patient's needs in any real sense.

The humanistic element of nursing care, the caring attitude, has almost universally received the endorsement of the academic nursing community and it is generally accepted that close attention to the feelings, needs, desires and thoughts of those cared for, and skill in understanding a situation from that person's point of view, are central to caring for someone (Noddings, 1995). Many consider empathy to be an essential aspect of caring practice (Cortis & Kendrick, 2003; Holm, 1997; Morse, et al., 1992; Omdahl & O'Donnell, 1999; von Dietze & Orb, 2000). Empathy can be described as an understanding of the other's world as seen from the inside, from their perspective, a sensing of the other person's private world as if it were your own (Rogers, 1961). Nurses are encouraged to empathise, to enter into the private world of patients to assist with their suffering, to view the world from the patients' perspective (Jackson, 2004c; Omdahl & O'Donnell, 1999).

Another interesting angle on this discussion is described by Nelson and Gordon (2006) who questioned the caring mandate, concerned that by emphasising the caring elements of the nursing role the technological and highly skilled aspects of the role are devalued and sentimentalised. They do not suggest that caring is unimportant but rather it is not the only important thing nurses do.

The combination of attitude and activity mesh together in nursing care, and as Gavin (1997) suggested:

Technically expert and safe care is possible without the emotional engagement of 'caring about' the patient. Equally, a nurse may engage emotionally and care 'about' the patient but not care 'for' that patient because of failure of her (sic) technical expertise. Good nursing is defined as an integration of both (p. 695).

Noddings (1984) extended the care for and care about debate when she presented the concept of engrossment or caring with. Caring involves, for the one caring she suggested, a feeling with the other, which is the initial step in the development of a caring relationship. Empathy is similar to the concept of caring with, but Noddings considered empathy a form of projection in that we project our feelings onto another, whereas engrossment is relational and focuses more on the relationship between the carer and cared for. Engrossment, which is a motivational shift, is not meant to imply a deep fixation; rather, it moves the focus from the nurse to the one
cared for. Noddings considered the response from the one cared for as necessary for the interaction to be caring. So, in addition to caring for and caring about there is caring with, which acknowledges motivation and a relational focus of caring. Not all caring experiences are directly relational, as I have outlined with global issues of care, and in some nursing situations there is little response from the patient, in for example, situations where a patient is unconscious. However, in an ideal environment, a relational aspect of care is seen as highly desirable. Interestingly, in a study carried out in the United Kingdom, patients and their families prized above technical skills and activities of care, having an interpersonal relationship with the nurse (Robinson, 1996).

Ideally, all aspects of care, motivation, activity, attitude and relationship are required to meet the needs of the patient. However, there are many things still to consider. Is having a caring attitude just about being kind or does there need to be an emotional connection or empathy for caring to be real and valid? Also, if the nurse does not naturally feel an emotion, can they pretend? There is no one answer to these questions. Hess (2003) stated that engagement or the caring relationship must remain a moral ideal, not a moral obligation and reinforced this statement by adding that caring is not a duty.

What is evident throughout the literature is the recurring theme that 'good' nurses care (Warelow, 1996) and an expectation is expressed that caring and having a caring attitude are imperatives of the nursing role. These points raise the question: If this caring attitude does not come naturally, can it be faked? Askinazi (2004) suggested not; “trying (author’s emphasis) to care doesn't pass for the real thing and even works against the essence of it” (p. 34); or, as Jourard (1964) a psychologist, suggested, the bedside manner of nurses can be “a peculiar kind of inauthentic behaviour that I believe does more harm than good” (p. 179). Although the words of Jourard may appear to be somewhat dated, they raise a question regarding whether anything has changed in practice or in people’s perception of nurses’ practice.

Interestingly, in Australia regardless of how nurses are portrayed in the media such as television, nurses are consistently rated within the top three professions that Australian people trust (retrieved 11 August, 2010 from http://www.readersdigest.com.au/ most-trusted-professions-2010). What happens when the impulse to care does not arise spontaneously or is potentially thwarted by
difficult circumstances or feelings? What happens when natural caring, as suggested through the writings of Noddings (1984), is not enough or does not happen? Little is understood about the care experience, in situations that are deemed ‘demanding’ or ‘difficult’ both as an ideal goal and as a reality of experience and these dimensions warrant further consideration.

The caring continuum

From a theoretical perspective, caring is discursively expressed as a moral ideal, not a moral obligation. Within Australia, however, where this study was carried out, a mandate for registered nurses to care is directly expressed in the ANMC National Competency Standards for the Registered Nurse (2005). Further, literature reveals that not to care is considered morally reprehensible or almost incomprehensible (Morse, Bottorff, Neander, & Solberg, 1991) or that caring is “part of one’s concept of a person: that an uncaring person is, to that extent, crippled” (Griffin, 1983, p. 289). Implied within the nurse caring literature is a tacitly held belief that, to be considered a good nurse one needs to care unequivocally. Caring is fundamental (Brilowski & Wendler, 2005), an authentic and intentional presence (Paterson & Zderad, 1988), an obligation (Maeve, 1997), a virtue (von Dietze & Orb, 2000), and the essence of nursing (Morse, et al., 1991). There is little consideration within the nursing literature of situations where care or caring might be difficult. Morse et. al. (1991) agreed with this observation and suggested caring has not received much critical comment and acknowledged that situations could arise where individual nurses could struggle to live up to the moral ideal.

While it is reasonable to assume that some individual nurses have prejudices and discriminating ideas about those who live in our society (as does the population generally), there is a general expectation that nurses should overcome or suspend moral judgements on others in the course of rendering care, regardless of how they may feel on a personal level. Norman and Parish (1999) stated that nurses must not be judgemental, but this imperative is hard to live out in the real world.

Little mention is made of situations that challenge the will of the nurse to care. In the words of Warelow (1996), “this tautology exhorts nurses to care and in some ways sets a dangerous agenda whereby nurses may begin to feel that unless one cares in a selfless, altruistic way then one is not a nurse (even a good nurse)” (p. 659). Interestingly, a fundamental aspect of nursing care, the emotional connection or caring about patients, was called into question by Curzer (1993). In assertions
raised by Curzer, he highlighted that nurse bias and personal preferences make it impossible to care for all patients equally. Therefore, he argued for a style of caring that was devoid of emotion, so that objectively nurses could care for all consistently.

Although not all would agree that by distancing ourselves, a caring relationship improves, Curzer’s assertion draws attention to the importance of achieving a balance of distance and intimacy, a balance which continues to be complicated. Watson (2000) suggested that to be vulnerable is to be human and added that, “if we are not able to be vulnerable with ourselves and others, we become robotic, mechanical, detached and depersonal in our lives and work and relationships” (p. 6). This description begs a question regarding the choice that nurses might make as they engage in care – should they elect to be vulnerable or robotic? Between these two extremes, there is a large area of middle ground and current descriptions of how nurses ought to conduct themselves do not do justice to the complexities involved in what Street (1990) described as the swampy lowlands of nursing practice.

What is clear is that there are some situations where nurses find it difficult to care. A number of authors have suggested over the years that nurses do not care for all patients with the same depth and concern (Baer & Lowery, 1987; Curzer, 1993). Research further suggests that nurses have negative attitudes towards groups traditionally perceived as disadvantaged, such as elderly, mentally ill and suicidal patients (Murray & Chambers, 1991). Hellzen et. al (2004) discussed caring in difficult situations such as those experienced when caring for patients with learning disabilities. If the patient’s behaviour is unpredictable and violent, they suggested:

   The meaning of caring for a patient exhibiting extremely disturbing behaviour seems to touch on moral aspects of human existence, the question of our willingness or unwillingness to be violated in a relationship (p. 4).

Similar thoughts are echoed by Curzer (1993), who suggested “it would require a saint to care for some really disgusting patients” (p. 58) – such as an unrepentant child molester, serial killers and highly manipulative sadists. Caring appears to be closely aligned with liking; “in day-to-day nursing practice, nurses are still uncomfortable caring for those they do not like or feel compassion toward” (Maeve & Vaughn, 2001, p. 52). Is it necessary to like a patient to be able to deliver care? Griffin (1983) argued that it is not, and went on to say:
Nor is liking necessarily part of the emotional element in caring, for this involves a desire to be in someone’s company, not, as in cases of love or infatuation, where this may not be rationally explainable—but because of what a person is like, in some way (p. 293, author’s emphasis).

Noddings (2002) explored situations whereby natural caring did not come as expected. She posed the concept that when natural caring failed to meet needs, a nurse has the opportunity to engage in ethical caring. In ethical caring, the caring response is subdued and does not evolve naturally. Noddings (2002) suggested that a response in these circumstances was to augment caring feelings by drawing on our own ethical selves, what we know as the right or ethical thing to do, similarly described by authors who write on reflective practice (Becker Hentz & Steen Lauterbach, 2005; Johns & Freshwater, 2005; B. Taylor, 2006). In ethical caring, one asks “What would I do in this situation if I really cared?” and then responds in that manner, drawing on memories of caring experiences.

Through her writings, Noddings acknowledged that straightforward, natural caring does not meet every need or situation, but I suggest that the alternative, which is ethical caring, could be considered as nothing more than pretence or ‘imitation’ caring. It can be argued that pretending to care is ethically immoral and should not be advocated as a way to care. In fact, one could argue that pretending to care works against the very fabric of what it is to care, as it is not honest and appears to lack the essential element of integrity. As Griffin (1983) asserted, “the ‘duty’ side is paramount in a nurse’s caring, and it cannot be a duty to have emotions. Indeed, duties often go against the grain, whereas liking goes with inclination!” (p. 293).

Nelson (1992) took another slant that added some depth to this discussion. Nelson argued that Noddings’ ethical care involved a kind of care that was unidirectional, blind and indiscriminate. This, she contended, was dangerous, as the caregiver had no moral basis for withdrawing from the relationship, no matter how damaging the relationship might be.

Jourard (1964) made an interesting observation about the ability to care when he suggested,

The more you grow as a person, the less shocked you become about people who are different from yourself. And in many ways, the more you grow, the more different and the more similar you become to everyone (p. 205).
This seems to echo Mayeroff’s (1971) sentiments about the ability to care being a journey of growth and self-actualisation. Much of what is written about caring practice may be hard to apply in circumstances where nurses struggle to live up to the high expectations they and others place on them. There is very little within the literature that discusses the implications of not caring or even acknowledges that there are aspects of caring which might be considered difficult for the nurse both personally and professionally (Maeve, 1997). What is available implies, either implicitly or explicitly, that not to care is a negative or inappropriate aspect of nursing care.

**Contexts of caring for prisoner-patients**

In this section of the literature review, I present an overview of the major health issues and concerns of prisoner-patients and the impact this has on their care needs, commencing with a description of the prisoner population. An evaluation of literature that presents issues confronting nurses who work in the perioperative field follows, with particular reference to the issue of caring for prisoner-patients in the operating room. Finally, I present findings from research that is specific to nurses who work in the forensic area. My exploration of the literature on prisoners aims at contributing to the overall understanding of the distinctiveness of this cultural group and the implications this may have for nursing care.

Claimed to be the most stimulating and revealing history of prisons and punishment ever written is Foucault’s (1975) genealogy ‘Discipline and punish’ (M. Cohen, Kahn, & Steeves, 2000). Historically, the pre-modern treatment of criminals was that of punishment, where torture and death were both a spectacle and the accepted method of maintaining social order. Punishment, as explored in Foucault’s work, was inflicted on the body; juxtaposed against this are current goals of imprisonment, not revenge but rather reform, where the punishment occurs behind closed doors and focuses on the soul (Sullivan, 1996). This history of prisons and punishment as outlined by Foucault is fundamental to any discussion of prisoners and describes power structures and institutionalisation, not only in the prison system, but also throughout modern society. Foucault’s concepts identify ways various welfare state institutions regulate life (Lancombe, 1996). He suggested power was exercised through techniques of objectification, classification and normalisation, in the prison system but also through professionals such as police, teachers, and social workers where there is (wittingly or unwittingly)
supervision and application of acceptable levels of behaviour such as that found in the prison system (Lancombe, 1996). This seminal work is frequently cited within much of the literature which follows on prisons and prisoners.

Prisoners hail from the general population and arguably could be any one of us. Individual prisoners are all unique; however, as a population group there are many common characteristics that combine to make them a distinctive sub-group of our culture. For example, the majority are men; (88%) reported internationally (Maeve & Vaughn, 2001; R. Watson, Stimpson, & Hostick, 2004). In Victoria the Department of Justice reports this figure as 93% men, with just 7% of the incarcerated population being women, a considerably different distribution than that found in the general population (Department of Justice, 2004). In all western countries, people of colour or indigenous populations are over-represented in prisons (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001; Dalton, 1999; Hufft & Kite, 2003; Maeve & Vaughn, 2001; Martin, 2001), 26% in Australia (Australian Institute of Health and Welfare, 2010) and, statistically, most prisoners originate from lower socioeconomic groups where there is an associated lower level of health (Evans, 1999).

Correctional health establishes a connection between the justice system and the health system. The justice system, in Australia and internationally, has increasingly had pressure placed on providing resources to the ever-expanding prison population (Doyle, 1998). The current expectation (developed since the 1990s), is that the corrections system is no longer just concerned with security but is also involved with all aspects of a prisoner’s life, including rehabilitation. The aim is to return the prisoner to society in a healthier (Maeve & Vaughn, 2001) or better state (Gondles, 2001) than when they entered the prison system. What is meant by better is not comprehensively discussed by Gondles (2001), but he did consider that “providing quality health care—both physical and mental—is a vital part of our efforts” (p. 6). This is no easy task. The first recently completed prison health study in Victoria concluded “there emerges from the plethora of results a picture of the prisoner population as an extraordinarily needy, unhealthy, and life-damaged cohort” (Department of Justice, 2003, p. 1).

Willmott (1997) suggested that custody affects care even when a prisoner is not ill, in that it removes the opportunity for the prisoner to practise self-care and initiate independent action. Prisoners have to ask nursing staff for even the simplest health
care remedies, and have to apply to see the doctor for minor ailments which, if they were not in prison, they would treat themselves with proprietary medicines. This, therefore, contributes to the extensive over-utilisation of health care services provided in prisons, which far exceeds the rate at which the general population accesses health care. The Victorian Prisoner Health survey (Department of Justice, 2003) suggested that 45% of prisoners had visited the prison health nurse at least once in the last month.

The major health issues identified as facing this population group are infectious disease, substance abuse and mental illness (Alemagno, Wilkinson, & Levy, 2004; Gladstone, 2005; R. Watson, et al., 2004). It is suggested that 90% of the prison population have a diagnosed mental health problem or substance misuse problem or both (L. Walsh, 2005). These issues warrant exploration, as they have the potential to influence nursing care delivery in an acute care setting, which will be shortly discussed. The prison situation has a specific cultural climate which Gondles (2001) suggested is difficult for those not exposed to the environment to understand. Doyle (1995) further identified that “prison is a unique social system where inmates live unwillingly and resentfully in a highly structured and controlled environment” (p. 58).

As a population group, prisoners have considerable health concerns, of which the incidence of infectious diseases is one. It is claimed that prisoners engage in lifestyles that put them at risk of infectious disease (Gondles, 2001). Many authors have acknowledged this when discussing drug use (Calzavara, et al., 2003; C. Cooke, 2002; R. Watson, et al., 2004), needle sharing (Calzavara, et al., 2003), tattooing (Stuppy, Armstrong, & Casala-Ariet, 1998), prison rape and transmission of sexually acquired diseases (Robertson, 2003). In addition, they elaborate further the prevalence of human immunodeficiency virus (HIV) and Hepatitis C among prison populations (R. Norman, 2001; Van de Mortel, 2003; R. Watson et al., 2004). North American authors such as Cohen (2000) suggest that up to one third of prisoners are infected with hepatitis C. HIV and acquired immune deficiency syndrome (AIDS) are found at seven times the rate of the general population (C. Cooke, 2002). Findings from Australian studies such as the Victorian Prisoners Health Survey concur with the overall prevalence of hepatitis C among prisoners at 39%, in comparison to the general Australian population of 1% (Department of Justice, 2003). There is little information to date as to the prevalence of HIV and AIDS in the Australian prison population.
Substance abuse among prisoners is discussed throughout the literature by many authors (Calzavara, et al., 2003; Carroll, 1995; L. Cohen, 2000; Holmwood & Rae, 2003; Lawrence & Woods, 2002; A. Norman & Parrish, 1999; R. Norman, 2001; R. Watson, et al., 2004). Substance abuse not only affects the health of the prisoners but also impacts significantly on their behaviour, the prison culture and the attitudes of staff towards prisoners. Cooke (2002), in a North American study, stated that 83% of prisoners admitted to drug use at some time in the past – 57% within one month of committing the offence for which they were incarcerated. In Australia 71% of prisoners reported taking illegal drugs within the 12 months prior to their incarceration (Australian Institute of Health and Welfare, 2010); with 17.5% reported as having used illicit drugs while in prison (Department of Justice, 2003).

A Canadian study suggested that, of those who use intravenous drugs while in prison, somewhere between 50–75% shared needles (Calzavara, et al., 2003). However, in Australia the reported needle sharing rate is lower with 20% of prisoners surveyed reported needle sharing within the last month (Australian Institute of Health and Welfare, 2010) although actual levels, not just those reported and needle sharing outside of the last month would increase this figure. This type of at risk behaviour (needle sharing) contributes to the continuing rise of infectious disease rates within the prison population (Lowe & Cotton, 1999).

Registered nurses who care for prisoners are aware of these statistics and it is reasonable to speculate that their responses of fear and mistrust of drug users might mirror those of society at large (McLaughlin, McKenna, & Leslie, 2000), an issue that had the potential to be unveiled in this research.

There is documented evidence on the impact of caring for substance abusers on health care workers. An Australian study examined the attitudes of nurses to patients (not just prisoners) who had a known illicit drug use problem. It was found that 42% of student nurses displayed a negative attitude towards individuals who used illicit drugs (R. Norman, 2001). Other Australian studies have found attitudes from nurses included a feeling that patients with a history of drug abuse or Hepatitis C were unworthy, demanding of attention and wasteful of resources (R. Norman, 2001). As I have previously reported (Crampton, 2007), the feeling that the patient may be seeking unwarranted analgesia as a result of their drug dependency can interfere with nurse attitudes and care. This attitudinal impact is also cited by others and adds to the complexities of caring for those who are known
substance users, such as those in the prison population (Carroll, 1995; Feigenbaum, 1995).

A major focus of the literature concerning the health care of prisoners is on meeting their mental or psychiatric health care needs. Many authors discuss the alarmingly high numbers of the mentally ill in prisons (C. Cooke, 2002; Encinares, et al., 2005; Gladstone, 2005; Maeve & Vaughn, 2001; Sigurdson, 2000). An Australian study in 2004 determined that health professionals had told 28% of the prisoners surveyed at some point in their life that they had a mental illness. A more recent United Kingdom survey reported 90% of prisoners had at least one mental disorder, with 70% having two or more mental disorders (Blakemore, 2009). Suicidal and self-harm behaviours are prevalent within the prison population (Department of Justice, 2004). Reportedly 46% of all Australian prisoners have had suicidal thoughts, with 10% having daily suicidal thoughts over the last 12 months. 27% of the total population surveyed have actually attempted suicide (Department of Justice, 2003). It is not surprising that depression following a sentence of incarceration is common in fact; in the face of incarceration it might be expected. Nor is the diagnosis of a personality disorder for the perpetrators of some particularly heinous crimes surprising.

The implications of the prevalence of mental illness, substance abuse and infectious disease among prisoners are multifaceted. First, these conditions are not isolated and it is important to note that many mentally ill prisoners abuse substances as well and so have a dual disorder (Peternelj-Taylor & Johnson, 1996). Therefore, this at-risk behaviour also places the prisoner at greater risk from infectious diseases. Second, perceptions from the community and health care workers are tainted by the belief that prisoners have added risks associated with their health care delivery (Carroll, 1995). Health care workers may have negative perceptions towards patients with personality disorders (McMillan, 2000) and those who substance abuse (Carroll, 1995). Moreover, it is possible that these negative perceptions could be magnified if the patient were also a prisoner. Notwithstanding this, for nurses each element identified in this discussion has the potential to place additional pressure on care delivery.

**Perioperative setting**

Three accounts were located in the literature that identified the experience of prisoner-patients within the operating suite (C. Cooke, 2002; Fyfe, 2004;
Thurmond, 2002) and another about prisoners in an intensive care environment (Graves, 2007). Many of the practicalities of the issue of prisoners and surgery have been identified and explored within the literature, but very little is explored about the impact on the nurse, emotionally or otherwise, when delivering care to prisoner-patients. An overwhelming theme within the discussions of prisoners within the operating suite was that of nurse safety. Safety presented itself in relation to the issues surrounding prison guards, handcuffs and escape. As a safety issue, guards are present not only to prevent escape (Thurmond, 2002) but also to protect staff (Fyfe, 2004). The presence and use of handcuffs on a prisoner-patient has a significant impact on a nurse’s ability to do their job on a practical level and also has far-reaching ethical implications. Within the literature, anecdotes of escape are prevalent, albeit with a comic touch. For example, the threat of escape was highlighted in an article by Parlow (2000), who outlined an incident where a patient was given rectal paracetamol intra-operatively and at this time the key to the handcuffs was found hidden in the patient’s rectum. This incident, although seemingly humorous, underlines a very real issue regarding the safety of personnel who care for prisoner-patients.

Practically, within the operating suite environment, the pressure of accommodating non-medically trained personal such as guards has implications. There are strict and rigid controls over maintenance of sterility and the sterile field and preparations for surgery. The assumption is that personnel within the environment have a sound understanding of these issues and their significance for the safety of the patient. In a practical sense, this means that personnel who work in the area will dress correctly, not eat or drink in the area, walk through designated doors to maintain clean/dirty sterile flows and keep well away from surgical equipment. These factors necessitate some understanding of the principles involved and the integrity to acknowledge an error immediately. The potential for a serious breach in sterility when non-trained personnel such as guards are present in the operating suite places additional pressure on the surgical team, in particular the nursing staff (Thurmond, 2002). Moreover, in cases of emergency, the presence of extra non-medical personnel coupled with the use of handcuffs may restrict access to the patient and hence potentially impede care giving activities.

It is noteworthy that studies have not been conducted to provide reliable or accurate statistics regarding the consequences of having non-medically trained personal such as guards in the peri-operative environment.
Ethical dilemmas abound in the context of guards and handcuffs being present within the operating room environment. First, the presence of guards limits the prisoner’s right to confidentiality, although it is noted that there is limited discussion about this aspect in the literature. The guards are always present, listening to all discussion regarding the patient, including situations where the patient is involved and aware, but also when they are unconscious and not involved in conversations about things such as their prognosis. In addition, guards are aware of information in the patient’s records that would not usually be available to non-medical personal. Fyfe (2004) added another concern, that of loss of dignity. How others see a prisoner-patient, especially in the prisoner system, can be important to them. The patient may understandably be apprehensive or frightened or have any number of other emotions regarding surgery. For guards, who are a part of the prison environment/culture, to witness this vulnerability places the prisoner in an exposed position. Again however, this aspect of the prisoners’ experience is seldom acknowledged in literature.

Holmes and Federman (2003) suggested that contact between nurse and their peers, whether they be other nurses, prison guards or medical staff, can impact on nurses’ perception of the patient, sometimes amplifying preconceived ideas. Guards may act as a visible indicator of a prisoner’s dangerous status. If the guards are keen to handcuff a prisoner or are present in larger than normal numbers or are armed, one can assume there is reason. Cooke (2002) suggested that while handcuffs and guards highlight the possibility of escape, they are also a visual reminder to all in contact with the patient of their prisoner status.

Literature is lacking that explores anything other than the practicalities of an encounter of prisoners in the operating theatre, such as ethical or emotional concerns. Graves (2007), for example, simply suggested that contact and personal conversation be kept to a minimum, but did not discuss what impact this would have on the caring dynamic. Thurmond (2002) mentioned the impact on the nurse of caring for prisoner-patients and suggested that the nurse must consider their own personal feelings or bias towards this particular patient population and use the same caring techniques. However, there is no discussion of the potential emotional burden for the nurse if they are unable to use the same caring techniques, the impact on the nurse that giving such care may have, or any exploration as to the moral and ethical implications of such care.
Custody care

Discussion in the literature establishes the existence of friction between the prison culture of custody and the nursing culture of care. The key issue of these opposing stances is a perceived incompatibility between opposing cultures of custody and care, which can cause many ethical and moral dilemmas. Many have contributed to the discussion (Gadow, 2003; Maeve & Vaughn, 2001; A. Norman, 1999; Peternelj-Taylor, 2004; Peternelj-Taylor & Johnson, 1996; Willmott, 1997; Zimmer & Cabelus, 2003). Gadow (2003) offered that:

> Imprisonment causes deliberate harm, while health care aims to prevent harm and improve well-being. If liberty is good and health includes freedom from gratuitous pain, health care and corrections work in ethically different directions (p. 161).

Aiyebusi (1998) suggested that expecting nurses to manage the conflicting roles of custody and care is problematic because the simple truth is that many cannot. This dichotomy between custody and care is a pivot at the cornerstone of the literature surrounding the nursing care of prisoners.

There are a few nursing theorists who have endeavoured to tie the concepts of nursing, caring and prisoners together in a philosophical framework (Gadow, 1999; Maeve & Vaughn, 2001; Peternelj-Taylor, 2003, 2004; Weiskopf, 2005). These authors have attempted to address the ethical and practical concerns facing nurses within this situation and place these concerns within nursing knowledge. To extend this discussion a review of what nursing literature contributes to the discourse on caring for prisoners is required. As such, several significant contributions are now explored.

Maeve and Vaughn (2001) used a critical hermeneutic standpoint in their attempt to deconstruct issues surrounding nursing practice with prisoners and identified three philosophic stances. The first approach was that of a caring perspective, which explored caring specifically in relation to prisoners. Caring, according to Maeve and Vaughn, is embedded in our moral being. Not to care is not to be moral (Maeve & Vaughn, 2001). While they acknowledge nurses can struggle to care for those they do not like or feel compassion towards, they consider that caring is what nurses do. Nurses must advocate for and maintain conditions that will permit caring to flourish, if they are to remain moral. The second approach Maeve and Vaughn identified was a forensic nursing perspective. Forensic nursing as a newly developed role faces some ambiguity of definition. Primarily this perspective
explores the evolving dynamic between custody and care. Custodial demands cannot relegate the value placed on care and the nurse is not synonymous with the prison guard. If custody supersedes care, the integrity of the nurse's role is lost and the nurse's ability to develop a relationship with the prisoner-patient is hindered.

Finally, Maeve and Vaughn viewed nursing prisoners from a penal harm perspective. The penal harm movement is a social perspective which emphasises punishment. In general, penal harm nursing exists when the nurse actively supports and enforces penal harm through nursing actions. For example, a nurse may respond to feeling that they were being manipulated by prisoner-patients by withholding an analgesic. This occurs when nurses are socialised to de-emphasise treatment and rehabilitation and instead regard themselves as an element of the prisoner-patient’s punishment. Maeve and Vaughn place caring as the foundation of any nurse–prisoner-patient relationship. Yet they also identified that any compassion and caring nurses may bring with them to the forensic environment is thwarted at the outset, as they are told not to hold conversations with prisoner-patients; that empathy will be their downfall; and to keep their distance: “nurses are substantively ordered not to care” (Maeve & Vaughn, 2001, p. 59). These three theoretical positions offer some explanation and a level of understanding of the experience of nursing prisoners; however, what is lacking is any depth of discussion about the experience for the nurse. Maeve and Vaughn acknowledge that while care is paramount to the nurse–prisoner-patient dynamic, there are times when nurses find it difficult to care for prisoner-patients.

Canales (2000) and Peternelj-Taylor (2004) suggested that in order to avoid negative consequences in the nurse–patient relationship, nurses must be able to assume the role of ‘other’ and view the world from another’s perspective. If the nurse is unable to achieve this, the potential exists for objectifying the patient, not valuing their humanity and placing the patient in the position of ‘other’, which limits the therapeutic relationship. Peternelj-Taylor (2004) explored ‘othering’ as a negative form of engagement with prisoners within correctional and forensic nursing. ‘Othering’ is the practice of objectifying prisoner-patients and referring to them using slang terms such as cons, psychopaths or monsters. The focus of Peternelj-Taylor’s work is on acknowledgement of the difficulties of the environment and the importance of developing a therapeutic relationship with a prisoner-patient. This can be particularly difficult if the patient has committed a grievous or heinous crime (Chaloner & Coffey, 2000). Peternelj-Taylor (2004)
added, “to understand the other is to understand the failure of multiple systems to address issues of poverty, interpersonal violence, substance abuse, criminalization of the mentally ill, and lack of access to health care” (p. 141). What Peternelj-Taylor offered is an understanding of the process of othering without offering to the nurse alternative strategies to deal with the complexities of nursing patients for whom care is difficult. There may be situations when the nurse does not want to place themselves in the position of other, if the other is someone who challenges the nurse’s ethical neutrality and evokes a strong response from them. These types of situations highlight individual and highly subjective experiences where the nurse may have no natural inclination to develop a relationship with the patient. Peternelj-Taylor offers little advice as how to deal with these circumstances.

Weiskopf (2005) examined nurses’ experience of caring for prisoners within the correctional environment. She found that the experience was different from all other settings, due to the strict boundaries set by the correctional system, and it was vastly different from the hospital setting. Nurses in the Weiskopf study described caring as ‘being there’, acknowledging suffering, possessing a non-judgemental manner, showing compassion, respect and taking time to get to know the prisoner-patients. However, Weiskopf found the experience of caring for prisoner-patients was filled with both real and potential physical and psychological risks, with no other health care setting presenting such restrictions to nurses’ free expression of caring. Weiskopf concluded by suggesting that more research is required to explore the experience of caring for prisoner-patients in a variety of roles and settings. Hence, the value of the present research is identified.

Hammer (2000) considered caring as part of the newly developed discipline of forensic and correctional health nursing and viewed it from a humanistic perspective, with its value, worth and growth potential for all humans. She proposed that caring was the one aspect of nursing practice that set nurses apart from the multidisciplinary team involved with the prison system.

She acknowledged that it was not always easy:

Caring for parents who have physically or emotionally abused their child may be difficult for the forensic nurse who has witnessed firsthand the results of that abuse. Yet, how can forensic nurses hope to reduce or eliminate this dysfunctional behaviour without caring for the perpetrator as well as the victims? (p. 23).
The impact of altruistic caring on the nurse is briefly touched on by Hammer, who acknowledged that coping skills may be required at a level not previously experienced by the nurse concerned.

Significant contributions have been made to the discussion of prisoner-patients by nurse philosopher Sally Gadow (1996, 1999, 2003), with much of her work focusing on the relationship between the nurse and patient. She considered that together nurses and patients develop a shared experience with shared meaning which she called the relational narrative. Together the nurse and patient seek the common good. In particular, Gadow valued ideas centred on the patient’s need for self-direction, their uniqueness and their dignity (Hess, 2003). Gadow’s work on nurse–patient interaction is considerable and adds to the dialogue on prisoners as patients. Like others, Gadow (2003) viewed nursing in correctional settings as ethically unique because of the contradicting custody–care perspectives. Gadow asserted nurses within the correctional system practise from differing ethical philosophies, and she offered three frameworks through which a nurse could engage with prisoner-patients: retribution, rational punishment and restorative philosophy.

Nurses who practice within the philosophy of retribution view the offender as other, place themselves on the moral or emotional high ground and feel little responsibility to care or to be caring. On the other hand, Gadow asserted that with rational punishment as a philosophy, nurses objectively detach and choose not to enter a relationship with the prisoner-patient. In this type of relationship, although the nurse may deliver the activities of care, they distance themselves emotionally. Gadow’s third description is a restorative philosophy in which it can be inferred that the nurse embraces both the activity and attitude of care in a relationship with the prisoner-patient, in which both seek the good in the situation.

A restorative philosophy enlivens Gadow’s ideas on the relational narrative between nurse and prisoner-patient. For example, although Gadow (2003) acknowledged that the dynamic between a nurse and a prisoner-patient offered an extreme test of the relational narrative (as the position of the prisoner-patient is “the least likely to be considered potentially valid”) (p. 166), she identified that through this difficult circumstance a nurse could embrace a relational narrative as a means of moving beyond judgement. In other words, through a difficult circumstance, a nurse and prisoner-patient could together create a shared meaning of their
experience. For some authors, the type of caring enacted may change with the circumstances, such as Noddings’ (1984) descriptions of both natural and ethical care. What is not transparent in either Noddings ethical care or Gadow’s explanation of the relational narrative is whether this experience is upheld to the same standard as shared meanings that occur between nurses and non-prisoner-patients. Is it possible that a nurse could enter the nurse–prisoner-patient relationship with good intentions and, through the process of the journey, derive some meaning that has significant negative impact on their ability to care for a prisoner-patient? What if the shared meaning evokes nothing that the nurse would choose to share? Although extremely appealing, further elaboration of Gadow’s constructs that elaborate on negative and positive narratives is required.

I agree with Gadow that, arguably, nurses may best address the relationship between care and punishment, because nurses practise both. Whether that relationship is one of congruence or contradiction is a question whose answer may redefine care for the profession as a whole. Gadow’s exploration of the nurse–prisoner relationship adds understanding at an ethical level, holding as an ideal a relationship or relational narrative between the nurse and prisoner-patient and yet the reality at the coalface is that the implementation of these ideals is difficult to achieve.

Situating care within a broader framework of personal and public morals suggests that caring is an imprecise and insufficient term to capture what nurses do and how they do it (Tarlier, 2004). There are many issues to consider when contemplating all that it means for nurses to care, in particular in complex moral and ethical situations, such as the relationship between the nurse and the prisoner. It is not just that, as some assert, non-judgemental care is required (Fyfe, 2004; A. Norman, 1999; A. Norman & Parrish, 1999; Thurmond, 2002). The activity of taking care of a patient, non-judgementally or not, if delivered impartially may not be the same type of care that is given to non-prisoner-patients. Dighton (1986) further highlighted this complex issue by suggesting that prisoners do not take to kindness and sympathy very well. They see it as a form of weakness to exploit or “be played upon for personal gain” (p. 49). There is insufficient investigation into the complexities of care in complex situations and how these situations affect the nurse. Further, the line between personal and professional boundaries blurs for many nurses when they attempt to care for prisoner-patients. Hess (2003) for example elaborated on Gadow’s work, claiming no dichotomy can exist between
the personal and professional if the nurse is to use the self in its entirety as a resource for nursing care. However, engaging the self may be asking much of a person in their professional role, dichotomy or not.

Chapter summary

In this chapter, I considered caring from a broad perspective and discussed its significance from global, social, personal and professional perspectives. Embedded in my discussion was an exploration of care as a motivation, attitude, action and relationship. I focused on theories of caring in nursing, and offered a view of caring as a continuum. At one extreme I identified the experience of not caring, where the caring experience was difficult or challenging; at the other extreme I offered a view of caring as natural and easy.

Prisoner-patient populations have several significant health care and social needs, which have an impact on the caring dynamic. Hence, the continuum of caring or not caring possibilities was highlighted in light of the characteristics of the prisoner-patient. I reviewed the contribution of nursing theorists and research to date about the nursing care of prisoner-patients. What is evident in current literature are theoretical and philosophical explanations regarding the complexities of caring for prisoners in the forensic environment. What is less well identified, however, is the lived experience of nurses who care for prisoner-patients in an acute setting, although this is acknowledged by some as worthy of further investigation (Gunning, 2000; Hammer, 2000). Authors have theorised about the relationship between nurses and prisoner-patients and provide a framework to apprehend the complexity of this situation; they do not, in the main, focus on the practical realities of caring for prisoner-patients in an acute setting, the focus of the current research.

The personal emotional investment of nurses when caring for prisoner-patients is virtually unrecognised and was certainly unacknowledged, but clearly involves feeling, and feeling involves personal vulnerability. The decision of any individual nurse to care for (or emotionally engage with) a patient is therefore one which exposes that nurse to the potential for personal costs or benefits as well as professional ones (Henderson, 2001). The ability of the nurse to build a responsive relationship with a patient despite different world views held by each reflects the moral and ethical knowledge that is the foundation of such relationships (Tarlier, 2004). It is this ability and desire (or not) of the nurse that will be explored further in this research. What nurses are not taught are ways to understand and cope with
their own responses to what they encounter (Jackson, 2004c). In the following chapter I explicate the philosophical underpinnings that form the framework for my research, where I explore nurses’ responses to prisoner-patients and whether they develop a relationship that is caring to both the nurse and the prisoner-patient.
Chapter Three:

Methodology
Introduction

In this chapter, I consider the methodological basis on which the research was constructed: that of Gadamerian hermeneutic phenomenology. Many different perspectives have developed over time that provide insight into how understanding and knowledge develop or are constructed. For example, an empirical–analytic perspective of knowledge construction is based on the assumption that knowledge develops through a systematic, rigorous, objective approach. In contrast, a phenomenological approach is based on an assumption that each phenomenon is unique and embedded within a subjective epistemology that honours individual experience. Researchers need to be aware of the different underlying philosophies and undertake research within a conceptual framework that embraces a style of research appropriate to their research goals, with awareness that in a very real way these methodological choices will impact directly on the process of doing the research. I chose Gadamerian hermeneutic phenomenology, because it is ideally suited to the goals of the research.

I begin by situating phenomenology within the arena of philosophical thought, moving to an overview that outlines the early history of the phenomenological tradition and delves into the conceptual development of several key thinkers within the phenomenological school of thought, namely, Husserl, Heidegger and Gadamer. These philosophers have made major contributions to the way understanding and knowledge is viewed, and their representations of the phenomenological tradition are discussed. Interpretative phenomenology, in particular the hermeneutic style of Hans Georg Gadamer, was selected for the current study and Gadamer’s key concepts are outlined. Discussion on the impact of Gadamerian principles on the research process and their influence on the method of understanding completes the chapter. Throughout the discussion, I explore the benefits of phenomenology as a philosophical and methodological framework and explicitly state the reasons why I chose this particular approach for the current research.

Historical influences on phenomenology

The original forefathers of philosophical thought are considered to be Socrates (c470–399 BC); his student Plato (c427–347 BC); and Plato’s student Aristotle (c384–322 BC). These philosophers embraced differing ideas about how understanding developed and they are attributed with laying the foundations of
western philosophy (Johnston, 2006). It is generally accepted that Socrates and Plato developed the science of metaphysics and extensively explored the concepts of truth and virtue (Boeree, 2000).

Plato believed that true knowledge did not change, and that knowledge was reality. Although beliefs and interpretation of the world, through our senses, can change. Plato asserted that these changes were not true knowledge. Plato believed that when a human being is born their soul knows everything about true knowledge, learning and understanding, which involves recollecting (hidden) memories. On the other hand, Aristotle suggested that understanding occurs through seeking the rules of nature and universal principles that we need to learn which, once discovered, enable the physical world to make sense (Goodman, 2007). He was fascinated with concrete facts.

Aristotle wrote about many topics and is credited with single-handedly founding the sciences of logic, biology and psychology (Johnston, 2006). According to Durant (1926), no other philosopher contributed so much to the enlightenment of the world. Aristotle’s foundational thoughts influenced Descartes (1596–1650) who moved away from ethics and subsequently disregarded perception of things as unreliable (Eysenck, 1994). Descartes is attributed with developing a rationalist model or deductive approach to reasoning that formed the basis of modern scientific thought. However, the deductionist approach led to the Cartesian mind/body, subject/object dichotomy, which separated what we know from the external world (Barnacle, 2001). Later philosophers such as Immanuel Kant (1724–1804) advocated a blend of rationalist, deductive thought and empiricist, inductive thinking and suggested that both intuition and understanding are sources of knowledge (Johnston, 2006). Kant believed scientific thought was informed by a priori knowledge which is independent of experience (Baeher, 2006). Ideas of these key thinkers are briefly touched upon here because they established the platform from which phenomenology developed.

The phenomenological tradition emerged in the later part of the 18th century through the work of Edmund Husserl. Phenomenology comes from the Greek word ‘phenomenon’ which means to show itself or to become visible (Heidegger, 1962). Husserl and Heidegger’s views represented a shift in focus away from a positivist cause-and-effect analysis, with its goal of establishing facts, defining truth and offering proof beyond doubt, towards the view that human experience contributes
to knowledge and knowing. Embedded within this concept is the exploration of actions, meanings and experiences of human life from the individual’s point of view. The goal of phenomenology is not to prove beyond doubt that something is universally true and exists in the same manner for everyone. Rather, it attempts to unravel the complex experiences that constitute the fabric of life, to develop deep understanding or knowing from differing perspectives. The focus on human experience is in contrast to the Cartesian subject/object split and other more objective approaches to knowledge construction. In fact, when studying the experience of people, I concur with other authors such as Turner (2002) and Dunbar (1998) that objectivity as it is traditionally understood should be abandoned.

**Husserl**

Edmund Husserl (1859–1938) is considered the founder of phenomenology. His early work was significantly influenced by Franz Brentano’s (1838–1917) notion of intentionality. Intentionality describes how all thoughts or consciousness is intentional; it refers to the relationship between internal thought processes, and the external world. Intentionality implies that in consciousness the mind directs its thoughts to an object (Mathews, 2002). In other words, “every thought is a thought of something” (Crotty, 1996, p. 39). The object of the thought does not need to physically exist; it could, for example, be something less concrete such as an emotion or feeling, but the premise, that every thought is about something, remains the same (Mathews, 2002). Husserl advanced the discussion about intentionality when he suggested that understanding is only ever in relation to an aspect of something. It is not possible to view something in its totality, because every view or thought encompasses perspective. To expand on this idea, one must adopt a succession of perspectives in order to develop a better sense of the whole (Giorgi, 2005). For example, if you look at an object like a chair, you initially only see one side of it; to obtain a sense of the whole you need to walk around it to see every aspect.

Husserl’s ideas about understanding were formed as a reaction against the scientific tradition, which suggested that all knowledge comes from something that can be proven. Husserl was a mathematician who did not completely reject the positivist tradition in that he recognised the value of such knowledge; however, he purported that a rigid scientific way of knowing did not encompass the totality of
everything worthy of investigation. He introduced the notion of *lebenswelt* (lifeworld) or lived experience, which is composed of the everyday world in which people live, and affirmed its value as something worth knowing. Husserl claimed *lebenswelt* was not easy to study because it consisted of things that were taken for granted or seen as common sense. He often referred to everyday experiences as “the things themselves” (Husserl, 1970, p. 252). The task of understanding for Husserl was to return to experiences and re-examine them; however, he advocated doing so with a positivist scientific edge (Koch, 1995). He stressed that the process must be done from the position of a detached observer, in order to enhance understanding of the experiences. Husserl’s contributions to the development of the phenomenological tradition are many. He expanded on the concept of intentionality and introduced the concepts of phenomenological reduction and essences. These ideas, intentionality, reduction and essences, form the building blocks of the phenomenological movement.

**Phenomenological reduction**

Husserl contributed to identifying how understanding takes place through the acknowledgement of the value of everyday experiences. He maintained that scientific objectivity is important to the phenomenon of knowing and objectivity is maintained by a process of phenomenological reduction, which is also referred to as ‘epoché’ from the Greek meaning ‘suspension of belief’ or bracketing, to use a mathematical term (Holloway & Wheeler, 1996). The three terms epoché, bracketing and reduction are synonymous. Husserl advocated that an individual who wishes to understand something must suspend their personal ideas and prejudices about the phenomenon, to enable them to develop an objective, non-judgemental approach to understanding (Dowling, 2004).

Bracketing remains a contentious issue within the interpretative paradigm. Those who utilise this technique assert that bracketing improves the rigour and objectivity of research (Gearing, 2004; Sadala & Adorno, 2001; Yegdich, 2000). They believe that the goal of the researcher is to shed all prior personal knowledge and biases to enable them to be open to interpreting the experience. Reality is considered to be objective and independent of history and context (Lopez & Willis, 2004). For other authors, the Husserlian premise remains an integral part of the research process. For example Yegdich (2000) stated that “bracketing is also indispensable for nurse-phenomenologist” (p. 33) and Salada and Adorno (2001) suggested that reduction
“cleanses the phenomena of everything that is ‘unessential’ and accidental in order to make what is essential visible” (p. 283).

However, the initial way in which Husserl described bracketing has been refined and altered over time. For Husserl, reduction meant the suspension of all judgements of the external world (Paley, 1997). Today most researchers who practise bracketing advocate a selective bracketing process, whereby only limited elements are bracketed or set aside. These elements could include the researcher’s personal beliefs about the specific topic undergoing study and any relevant preconceptions they hold. Alternatively, bracketing may be utilised to focus on the external essences of an experience being studied, setting aside its history and environmental factors (Gearing, 2004). Although the modifications of the original concept are said to resonate with Husserlian tradition, they have changed its focus and moved away from the original concept (Paley, 1997). Gearing (2004) suggested:

> The growing disconnection of the practice of bracketing in research from its origins in phenomenology has resulted in its frequent reduction to a formless technique, value stance, or black-box term (p. 1429).

Two other concepts Husserl highlighted are essences and intentionality. When understanding an experience once all the external judgements from influences and history associated with that experience are set aside or bracketed, what remains is what Husserl referred to as the essence of the experience. Husserl considered essences to be the real meanings of things, which are generally unique to each individual. In the vein of a traditional scientific approach to knowledge construction, Husserl believed that essences could be abstracted from lived experience without considering the context, and it is in this process that Husserlian phenomenology attempts to be objective (Koch, 1995). Some essences are universal and common to all those who have the experience, and as such are not unique to an individual (Lopez & Willis, 2004). According to Van Manen (1990), if an essence is a phenomenon, universal essences are the themes of the phenomenon.

Husserl viewed intentionality as the act of consciously focusing on a phenomenon while removing preconceptions from the framework. Intentionality, he claimed, revealed the etic structure of the phenomena, which is the ‘scientific’ basis for Husserl’s development of phenomenology. Husserlian phenomenology was concerned with “the clear understanding of the fundamental nature of reality”
(Walters, 1995b, p. 792) and many eminent thinkers developed the phenomenological tradition from this concept.

**Hermeneutics**

Another significant interpretative thought process, hermeneutics, developed alongside phenomenology and became an increasingly influential concept. Hermeneutics was originally developed to understand biblical text in context, but the focus gradually expanded to encompass secular considerations of understanding. Hermeneutics is now regarded as the study of the theories applied to interpreting and understanding texts. In addition, it is also a philosophy of understanding (Geanellos, 1998a). The application of hermeneutic thinking to a broader context is attributed to Frederich Schleiermacher (1768–1834) who acknowledged the importance of history and the role of the interpreter in contexts other than biblical exegeses (Turner, 2003). William Dilthey (1833–1911) applied Schleiermacher’s concepts to the process of understanding and reinforced the importance of considering the history of parts in relation to the whole. As Phillips (1996) suggested, Schleiermacher and Dilthey broadened the focus of hermeneutics to expand the concept of text to extend beyond the written word to include verbal and non-verbal elements, both historical and current. Some consider Dilthey’s foremost contribution was the value he placed on the past and the influence history has on the way we understand things today. Dilthey’s assertion was that “we are irredeemably historical” (Lawn, 2006, p. 53).

Thus, hermeneutics has two foci; first, the traditional interpretation of text and second, a deeper interpretation of how we understand, which Gadamer called philosophical hermeneutics. Gadamer agreed with Dilthey that hermeneutics was at the heart of all forms of understanding and his philosophy will shortly be discussed. He, along with others such as Ricoeur, is credited with synthesising hermeneutics and phenomenology (Thompson, 1981). Merging the two disciplines, of hermeneutics and phenomenology shifts the focus to embracing history and context as imperative aspects of interpretation. Weinsheimer (1985) stated, “like Heidegger, Gadamer (2004) considers hermeneutics so basic, so intimately implicated in the life-world, that it is universal” (p. 36). The emphasis on context and history places interpretive phenomenology in an entirely different arena from Husserl, who searched for and actively used objectivity in his quest for understanding.
Heidegger

Martin Heidegger (1889–1976), a student of Husserl, moved away from the focus on scientific rigour and the pursuit of irrefutable facts to phenomenology as the search for an historical record of human experience. Heidegger was not opposed to science in general; rather, he considered that both scientific knowledge and everydayness had value (Paley, 1998). In contrast to Husserl’s Cartesian affinity, Heidegger embraced the importance of an individual’s context, history and environment. He believed that knowledge of the world could not be detached from being in the world, nor subject from object (Weinsheimer, 1985), at which point the emerging hermeneutic ideas became enmeshed with phenomenology. This was a significant move away from the phenomenological thinking of its time and many philosophers would consider the influence of context to be Heidegger’s most significant contribution to the growth of phenomenology.

To explore the focus on context further, Heidegger considered that an important element of phenomenology was the ontological question ‘What is being?’ He advanced the study of phenomena from an existential ontological perspective by acknowledging that observers cannot separate themselves from the world because they are part of it and inextricably tied to it (Leonard, 1994). His notion of dasein, which is defined as ‘existence’ or ‘being that is in the world’ encompassed environment and included the concept of lifeworld or people’s everyday realities. He believed humans cannot extract themselves from the world and their realities and perceptions are invariably influenced by the world in which they live (Lopez & Willis, 2004). Thus, Heidegger believed understanding is not a way of knowing but is a mode of being in the world. The relationship between individuals who live in the world and the world itself is a fundamental issue for many phenomenologists. Exploring how the lifeworld might contribute to commonalities and differences in the subjective experiences of any individual is the point of exploration (Lopez & Willis, 2004). Moreover, the most fundamental way of being in the world is sorge (Heidegger, 1962). This word is usually translated into English to mean ‘care’. Sorge encompasses being and caring for things and other people (Walters, 1995b). Heidegger (1962) believed care was at the core of being human.

Once Heidegger established the importance of a person’s context to their existence, phenomenological reduction became implausible or even impossible. Heidegger felt reduction was not feasible because it was an abstract concept that
could not be attained in any real sense. As discussed, the combination of hermeneutics and phenomenology highlighted the transition Heidegger and Gadamer made from describing phenomena to interpreting them. An interpretative focus emphasises the importance of understanding and all that it entails; understanding not just the experience being studied, but also the context, the history and the impact that experience has on the process of understanding. When discussing this, Burke Draucker (1999) asserted that “experiences can only be understood in terms of one’s background, or historicality, and the social context of the experience” (p. 361). Understanding and its relation to context is an important premise and the philosophical basis on which the current research is based.

**Gadamer**

The current research was based on Hans Georg Gadamer’s (1900–2002) philosophy of understanding. Gadamer’s main theoretical contributions to the development of the phenomenological tradition are outlined in the next section. Gadamer’s key concepts are discussed and the way his ideas were utilised as the basis of this research is described.

Gadamer was a student of Heidegger, and was influenced by him. Like Heidegger, Gadamer (2004) advocated a return to a humanistic tradition because, he believed, the understanding of human beings could not be achieved using the concepts utilised by modern science. Gadamer moved Heidegger’s philosophy towards ontology (Figal, 2002; Koch, 1995), by exploring what *dasein* or ‘being in the world’ meant when identifying how things are communicated or understood between individuals. Significantly, like Heidegger, Gadamer believed that the world could not be studied from the position of detached neutral observer. Much of Gadamer’s philosophical discourse concerned the process of understanding; hence the following section commences with a discussion about understanding.

**Understanding**

For Gadamer, understanding meant many things; among them he placed a strong emphasis on language and communication and the influence of history and context. Gadamer considered communication was primarily achievable through language or text. The word ‘text’ has a more general application than just written words: it includes spoken and non-verbal records and every product of culture like art and music (Weinsheimer, 1985).
Gadamer asserted that, in order to be understood, information needs to be communicated among individuals. An individual needs to articulate a meaning, a thing or an event into words (Grondin, 2002). Language is one vehicle that makes understanding possible and it cannot be overlooked. As Gadamer suggested, understanding is constantly filtered through the medium of language. Language provides both understanding and knowledge (Weinsheimer, 1985). Or, as Gadamer (2004) stated, “being that can be understood is language” (p. 470). It cannot be ignored that language can also be the means of misunderstanding and that there is a relationship between what is said and what is understood.

A discussion about the importance of language and its relationship to understanding must be accompanied by description of how understanding occurs. That is, how words or text are received and refined by the person understanding. An emphasis on language highlights the means or medium by which understanding develops between two people (Gadamer, 2004). Gadamer felt understanding begins with conversation, that is, conversation is a significant part of the process of coming to an understanding, either through common sense regarding a common concern or an attempt to reach such a commonality (Weinsheimer, 1985). Therefore, for Gadamer, language is significant in that it is the medium through which understanding or sharing ideas among people takes place. The sharing of ideas exemplifies the responsiveness, creativity and freedom which is so central to understanding (Sharkey, 2001).

As well as an emphasis on language and communication, Gadamer placed considerable importance on the historical context in which understanding takes place, which is the point where hermeneutics integrates with Gadamerian thought. Hermeneutics is concerned with understanding and interpretation in a way that moves beyond text and language (Figal, 2002). It embraces the influence history has on us all.

**Situatedness**

For Gadamer, shared knowledge is found within tradition. Tradition in this sense refers to shared culture, language and history and is an important aspect of people’s past, present and future views, which Gadamer referred to as situatedness. Hence, the three elements of language, communication and history are the foundations of Gadamerian thought. The historical influence of understanding encompasses a person’s individual situation and the influence it has
on their ability to perceive and know. That is, understanding is the culmination of peoples experience and the way they view the world, and that experience influences their ability to understand, referred to as the hermeneutic circle. The position or situation people find themselves in and the impact that has on their ability to understand is described by Gadamer as a form of prejudice, because understanding is always viewed through interpretation.

In Gadamerian thought, position influences the way one interprets the situation; we understand filtered by our own view of the world. What we understand about ourselves has impact on everything we know (Weinsheimer, 1985). As CharlesTaylor (2002) suggested, there is “no understanding of the other, without a changed understanding of the self” (p. 141). Therefore, understanding is a constant movement or interplay between our self and the other. The interplay between context and history and oneself is fluid and constantly changing, dynamic, and constantly evolving. Taken a step further, the interaction between the changing nature of experiences and seeking to understand influences the ability to understand.

Gadamer (2004) suggested that “a text is understood only if it is understood in a different way as the occasion requires” (p. 308), which is an interesting concept because the text itself does not change; the change occurs in the individual seeking to understand or the context in which it is interpreted. Arthur Frank’s (1995) work on the wounded storyteller shows Frank has similar ideas about the relationship between history and interpretation:

> The scientific notion of reliability—getting the same answer to the same question at different times—does not fit here. Life moves on, stories change with that movement, and experience changes. Stories are true to the flux of experience, and the story affects the direction of that flux (1995, p. 22).

Our situatedness, our understanding, and our ideas are evolving and changing all the time. The impression an event makes is not necessarily the same six days or six months later. I applied this concept in my research, for example in my decision to interview each participant twice, as well as observe their practice on several occasions. Through these decisions I embraced the belief that each contact would further my understanding and consequently my understanding would grow and change. Because Gadamer asserted that understanding depends on the particular historic situation in which it takes place, it was essential to be mindful of this premise when I attempted to understand what the participants were saying.
Therefore, I returned to the interpretative process several times, seeking to identify the influences and history that shaped the experience.

Situatedness, history and understanding culminate in Gadamer’s notion of *Wirkungsgeschichtliches Bewusstsein*: the awareness that one’s own understanding is affected by history or, as Weinsheimer (1985) states, “the consciousness that consciousness is affected by history” (p. 199). This concept encompasses the notion that there is always more to history than can be understood; one can never know it all. When an individual comes to a position of understanding, it is a culmination of all their past experiences. This is not a finite or stationary position, as people are constantly moving through understanding and changing as they go through life. There is a strong link for Gadamer between understanding and interpretation; he asserted that “interpretation is not an occasional, post facto supplement to understanding; rather, understanding is always interpretation, and hence interpretation is the explicit form of understanding” (Gadamer, 2004, p. 306). This association between understanding and interpretation culminates in the hermeneutic circle.

**Hermeneutic circle**

Gadamer explained the path of the hermeneutic circle as the way understanding develops and expands through interpretation. Heidegger felt that the circle described the relationship between “understanding (*verstehen*) and its unfolding in the interpretative process (*auslegung*)” (Grondin, 2002, p. 47). To elaborate, Gadamer (2004) believed the hermeneutic circle described understanding in terms of the whole and parts: “we recall the hermeneutic rule that we must understand the whole in terms of the detail and the detail in terms of the whole” (p. 291). The hermeneutic circle and its movement between parts and whole means there is no true starting point for understanding; the parts precede the whole and the whole precedes the parts in a circular motion (Geanellos, 1998a). Gadamer’s view of knowledge can be described using the analogy of looking at an image through a camera lens. Alternating the close-up focused shot with a wide panoramic view allows one to see both the detail and obtain a sense of the whole required to understand the complexities of the picture. Without both, it would be difficult to grasp the intricacy of the picture. The movement between parts and whole describes not what interpretation should be, but rather what it is (Weinsheimer, 1985). In addition, Gadamer asserted that it is not possible for the interpreter to
remove themselves from the process; the one seeking to understand is placed within the hermeneutic circle rather than being external to it (Dowling, 2004). The hermeneutic circle influenced my research method in many ways. The concept of breaking things down into parts to understand, then referring back to the whole, occurred throughout my research and framed the way in which the interview transcripts were interpreted.

Pre-understanding and prejudice

Having discussed the influence of the interpreter and history and the inevitable impact they have on the process of understanding, the discussion now turns to the concept of pre-understanding. As discussed, Gadamer felt human understanding does not happen in a vacuum, it happens within a historical and cultural context. When an individual seeks to understand, they bring their pre-understanding, which shapes the interpretative process. Pre-understanding derives from people’s social and cultural experiences, which contribute to the person they are; that is, their history. These ideas are echoed by Bourdieu (1984) who wrote about habitus, which describes a person’s belief systems and values.

An acknowledgement by researchers of what their pre-understandings bring to the process is necessary to facilitate understanding. The concept of prejudice is closely related to the concept of pre-understanding and these terms are sometimes used synonymously. Prejudice is an element of all knowledge that influences pre-understanding or world view. Gadamer regarded prejudice as a value position. However, Gadamer’s use of the word embraced more than the traditional meaning of the word and its negative connotations. Gadamer felt a prejudice can be either positive or negative and is influenced by characteristics such as gender, race and class. Irrespective of its positive or negative value, it inevitably influences understanding (Gadamer, 2004).

Gadamer argued that only through prejudice we can begin to understand. “Prejudice is a forestructure or a condition of knowledge in that it determines what we may find intelligible in any given situation” (Koch, 1996, p. 177). Therefore, prejudice is an inevitable aspect of understanding and describes our position in the world and the perspective from which we understand. No one has the same experiences or history; thus it stands to reason that everyone understands from a different perspective and through different prejudices. The dynamic between self
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and understanding and the uniqueness of the experience in any given situation is crucial to grasping what Gadamer referred to as the process of understanding.

Gadamer never spoke directly about research; rather he spoke in more general terms about ‘understanding’. To apply his thoughts to the research process, the researcher is always considered to be an active and integral participant in the interpretative process, rather than a passive recipient of knowledge (Walters, 1995a). When applying these concepts to my research, I was intimately and integrally involved in the research environment: the operating suite of a large metropolitan hospital and the phenomenon of nursing care of prisoners: the topic of investigation. A philosophy that accommodated my involvement was ideal and is one of the reasons I chose a Gadamerian approach as the philosophical framework for my study. An awareness of pre-understanding is imperative for the process of understanding to occur, because it is not possible to eliminate experience (Gadamer, 2004); the ideal is to acknowledge and understand, because experience is inextricably linked to interpretation (Thompson, 1981). Therefore, the researcher must be aware of their pre-understandings or prejudices, identify relevant issues and reflect on them in order to expand their horizon of understanding. In one sense interpretative phenomenologists are similar to cultural anthropologists who try to clarify their own culture prior to entering another culture, but who expect to have their own cultural assumptions made visible and challenged in new ways by actually living in the study culture (Benner, 1994a).

The process of acknowledging and developing an awareness of my own pre-understandings and prejudice throughout the project was difficult and having experienced the phenomena first hand placed me at considerable risk of seeking to affirm my own truth. Situating myself as both knowing the phenomenon of interest on one level, but also opening myself to the experiences of others through adopting an attitude of Bildung (see page 64), however, led to ongoing personal growth, which was achieved through working within transparent processes, ongoing self-reflection, journalling and actively seeking critical feedback from my supervision team.

Pre-understanding and the hermeneutic circle

A researcher such as myself, who uses the reflective process to understand, must acknowledge that pre-understandings are woven within the hermeneutic circle. Understanding is achieved by revisiting initial perceptions many times and through
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asking the self critical questions about prior understanding of the phenomenon under exploration (Fleming, Gaidys, & Robb, 2003). Practically, in this research, the continual revisiting of pre-understanding to gain insight occurred in several ways. At this point it is necessary to say that the process needs to be visible and integrated into all steps of the research process, including planning and implementing the research and presenting the study findings and the discussion. Pre-understandings also need to be identified in sufficient detail, so the reader becomes explicitly aware of the influence the researcher had during the entire process (Fleming, et al., 2003).

Not addressing issues of pre-understanding places a researcher at risk of confirming their own truth, rather than revealing the truth of the phenomenon under investigation (Geanellos, 1998b). As mentioned, hermeneutics acknowledges that understanding proceeds through the researcher’s pre-understandings and, as such, acknowledging and integrating pre-understandings within the research process is imperative (Geanellos, 1999). Omitting any discussion regarding pre-understandings is common, especially in nursing research (Geanellos, 1998a). Such significant oversights limit the trustworthiness of the process and the findings of any hermeneutic-based research design.

Bildung

_Bildung_ is generally translated to mean ‘openness to meaning’ and is a significant concept which permeates my research. Originally, _Bildung_ was intimately associated with the idea of culture. Gadamer (2004) suggested it designated a human way of developing natural talents and capacities. However, Gadamer extended the meaning of the word to encompass culture, to refer to ‘openness’ in the way that people are open to the influence of culture. Being receptive to aspects of culture is outside an individual’s usual frame of reference. Gadamer regarded _Bildung_ as being crucial to his concept of understanding and suggested:

> Keeping oneself open to what is other – to other, more universal points of view. It embraces a sense of proportion and distance in relation to itself, and hence consists in rising above itself to universality (Gadamer, 2004, p. 15).

In _Bildung_ then, one leaves what is familiar and accepts what is different (Weinsheimer, 1985). Philosophically embracing an attitude of _Bildung_ is quite different from utilising Husserl’s description of bracketing, where one approaches knowing as a tabula rasa. Interestingly, both Heidegger and Gadamer viewed the
process of bracketing as counterintuitive to the result, and each advocated that understanding occurred through the utilisation of situatedness and one’s history. From a contemporary perspective, Benner (1994a) considered strategies for creating openness to be imperative to developing trustworthy interpretative phenomenology. The implicitness of Bildung was a cornerstone of the conduct of my research and the process I used to achieve Bildung is explicated in the methods chapter.

Horizons

Understanding is never final: it is always an ongoing process (Gadamer, 2004). Gadamer’s metaphors of horizon and fusion of horizons facilitate a clearer visualisation of what is meant about the relationship between situatedness and understanding. The idea of a horizon is that it marks the limit of everything that can be seen from a particular point of view and also implies there is more to see beyond the immediate standpoint (Weinsheimer, 1985). Moreover, it is important to emphasise that a horizon does not remain static; it moves as a person’s position changes. Hence, as understanding occurs, horizon shifts, as one’s horizon is mobile and fluid. Gadamer regarded horizon as an individual’s particular point of view and all that entails. It includes their situatedness, historical influences and their pre-understandings or prejudices that enable them to make sense of the world.

Horizon is another way of describing context. It includes everything a person is immediately aware of, as well as things they are not immediately aware of, and which they must, in fact, remain unaware of, to enable them to focus. Otherwise, the task of understanding would become overwhelming. The horizon or prejudice that each researcher brings to a study influences the research process and must be acknowledged (Whitehead, 2004). In fact, an individual’s present horizon is continually being formed and tested and an important part of the testing occurs through encountering the past and understanding the tradition from which they have come (Gadamer, 2004).

Fusion of horizons

Fusion of horizons is a metaphor for understanding (Koch, 1995). Gadamer regarded the fusion of horizons as the process by which one opens up to the standpoint or view of another and is influenced by that viewpoint. One’s points of
view or understandings, which connect individuals and impact upon each other, change those involved as understanding is sought. Fused horizons can be among people or between a researcher and text in whatever format. Gadamer suggested that fusion of horizons occurs when our own horizon is understood in order to understand another’s (Turner, 2002).

Hermeneutic research is faithful to the horizons of the participants but also includes the researcher’s own comprehension and interpretative insight (Sharkey, 2001). Hermeneutic phenomenology is concerned with understanding what an experience is like for a participant. The process of understanding occurs as a joint venture between the researcher and the participant to achieve a fusion of horizons and is influenced by the pre-understandings, prejudice and historical positioning of all concerned, as already discussed. The concept of fusion of horizons, is regarded as an ideal position because it can never be fully completed or achieved (Lawn, 2006). When applying this concept, it is worth mentioning that the fusion of horizons achieved in this research would have been different if the research had been attempted at a different time, with different participants or with a different researcher.

**Moving from methodology to method**

Having explicated the philosophical assumptions upon which the research was based, I now briefly offer an explanation of how methodology influenced method. A detailed description of the research method used to conduct the study appears in the next chapter. In the research, I explored the experience of nurses caring for prisoner-patients. I realised from the outset that the understanding I was seeking needed to be explored on a deep level to enable me to richly grasp what it was like to participate in this particular nurse–patient experience. Phenomenology resonated with me as a valid means of exploring the topic because I was seeking to discover meanings that registered nurses attached to their personal experiences of caring for prisoner-patients: ideas that were unique to them as individuals and to the environment in which they worked.

I acknowledge that more than one research method could have achieved this aim; however, I selected hermeneutic phenomenology for several reasons. As a researcher, I found comfort in embracing a philosophical construct that emphasised the value of experience and acknowledged the individuality of that experience. I embraced the idea that life is complex and when viewed by individuals from
different perspectives would elicit unique and diverse ideas. I was seeking a methodology that would encompass these philosophical orientations and allow horizons to emerge.

In conducting the study, I made no attempt to predict or control what was shared, because I appreciated that the diversity of experience as well as its similarities would contribute to my overall understanding of the phenomenon. I was also aware that understanding is constrained by social conventions and expectations about what nurses ought to think or believe. Hence, I selected a research methodology that enabled me to probe the participants’ expressions for hidden or obscured meanings.

Finally, I was intimately situated in the experience of being a registered nurse who cared for prisoner-patients and my situatedness was the impetus for the project. I acknowledge that I have considerable influence in the area where the research was undertaken and, while I realised that I had clear ideas about what I thought about nurses nursing prisoners, I had limited understanding of what other nurses thought and whether their ideas resonated with my own. Therefore, I used a research approach that respected the role I played in the interpretative process and one that felt right to me and the participants. Within this philosophical framework, I was central to and intimately involved with the process of understanding. However, I did not regard my opinion and pre-understandings as supreme.

Throughout my interaction with the participants, I remained open to discovering the new meanings that participants contributed about the complex phenomenon of registered nurse care of prisoner-patients within an acute care environment. Further, it would have been difficult to isolate myself from the process of understanding. Therefore, I embraced a Gadamerian perspective and acknowledged the fact that understanding occurs as a joint process between researcher and participant. By utilising the hermeneutic circle, I was able to embrace the contributions of the one who was trying to understand (myself) and the ones who also understood (the participants) and engaged in the co-creation of new meaning, about the phenomenon of registered nurse care of prisoner-patients.
Chapter summary

The methodological choice of Gadamerian hermeneutic phenomenology as the philosophical framework for the study was made for many reasons, particularly because the philosophy of understanding enabled me to acknowledge my situatedness as a researcher. Researcher influence was discussed throughout the chapter as being significant to achieving understanding. By acknowledging my standpoint, and the way understanding occurs, I maintain that my familiarity with the care of prisoner-patients contributed to rather than detracted from the end result. It enabled me to genuinely and authentically hear what the participants shared, and contributed to the development of mutual understanding over time. In the introduction to his work *Truth and method* Gadamer (2004) stated that “my real concern was and is philosophic: not what we do or what we ought to do, but what happens to us over and above our wanting and doing” (p. xxv). This is really at the heart of the matter for the research question. I did not intend to develop policy, critically analysis events or to change practice but, rather, to understand it.

The development of a methodological framework is essential to the conduct of a sound research project. In this chapter, Gadamerian hermeneutic philosophy and its influence on the methodological approach was discussed. The importance of Gadamerian principles of historicality, pre-understanding, prejudice and the hermeneutic circle were highlighted in relation to method and choices, which define the research design. The following chapter expands on how theoretical influences impacted on the research methods used to undertake this study.
Chapter Four:

Method
Method

Introduction

In this chapter, the processes I utilised to collect data and gain understanding of the phenomenon of registered nurses caring for prisoner-patients within a perioperative setting is described. The philosophical framework which guided this study and the choices I made regarding the study method(s) are intimately related. Hence, the interplay between these experiences and Gadamer’s philosophy of understanding are outlined in this chapter. The aim of the research was to explore registered nurses care of prisoners-patients. While there are a few studies reported within the literature which explore the experience of registered nurses caring for prisoner-patients in the forensic setting and these are identified in the literature review chapter, none are from an Australian perspective and there are none that consider the experience from the standpoint of a general nurse in an acute hospital, outside of the forensic setting.

The study findings can potentially provide health professionals with insights into the experience of caring for prisoner-patients, by exploring the experience of others. They can also give greater understanding to the caring dynamic between nurse and patient in a real and demanding environment. In this chapter the study method which facilitated deep exploration of the phenomenon under consideration is unveiled. A multifaceted approach was used to elicit the experience of caring for prisoner-patients: a) conversational semi-structured interviews; b) observation of participants providing care for prisoner-patients; and c) keeping a reflexive journal.

Several significant ethical issues were manifest in this research and in this chapter; I focus on two ethical issues. First, the prison population is especially vulnerable; therefore, protecting this patient group was paramount. Second, having worked in the environment where I undertook this research, I had both significant experience and pre-understandings on the nurse–prisoner dynamic, as well as established relationships with the nurses I wanted to interview. These two facets significantly influenced my study design, and the processes that I used to maintain ethical integrity throughout this research are described in this chapter. Finally, I demonstrate the trustworthiness of the data gathering process by describing a transparent and clearly outlined research decision trail, which indicates the reasons for the choices I made and clearly explains my methodological decisions and their influence on the research process and findings.
The study setting

The research was conducted in a large metropolitan hospital in an Australian city with a population of approximately four million people. The hospital is a publicly funded acute general hospital owned and run by a religious order. The hospital has a long held mandate to care for prisoners and other disenfranchised people and consequently the hospital provides surgical services to the prison population. Within the main hospital building is a secure ward where prisoner-patients receive care. When leaving this area for any other part of the hospital, a prisoner is accompanied by prison guards and/or federal police depending on their predetermined security risk. The main operating theatres where I work as an educator perform a total of 40–50 operations a day in a number of operating theatres. Prisoners present for surgery on average about once a day or 350–400 times a year. The study involved registered nurses working in the post-anaesthetic care unit which has 16 bays and a nurse–patient ratio generally of one nurse to one or two patients, depending on patient acuity.

The study participants

At the time the study was conducted there were 50 nurses working in the post-anaesthetic care unit, which included part-time and casual nurses, nurses rotating from other areas of the hospital and students who were specialising in the area. All nurses who worked in the post-anaesthetic care area of the hospital, who had been employed in that area for at least the previous six months and who worked a minimum of 24 hours a week were invited to participate (total of 34 nurses). The only exclusion criteria were that post-graduate students whom I currently supervised and taught were excluded from participating, to protect them from potential teacher–student power imbalances. This left 29 potential participants, all of whom were over the age of 18 and able to speak English fluently.

From the available pool of potential participants 15 registered nurses who had undertaken a course leading to the award of Bachelor of Nursing consented to participate in the research and 12 were consequently selected. Of the 12 nurse participants 2 were male. Their experience within the perioperative environment at the end of data collection ranged from 2–17 years (average 6), and ages ranged from 22–46 years old (average 31). Of the 12 participants, 8 had completed postgraduate studies in the area, which involved them undertaking an additional year of study at university and 2 had recently completed their graduate nursing
year, considered in Australia to be an ‘entry to practice year’ during which newly graduated nurses are expected to consolidate their knowledge and practise skills that they learned at their university course. It is worthwhile mentioning that in Australia, all registered nurse education is undertaken in the higher education (university) sector.

To protect the anonymity of participants, a pseudonym was ascribed to each participant. Personal characteristics that could potentially identify individual participants were altered or deleted during transcription of data, and in publications arising, including this thesis.

The recruitment process

a. Gaining consent of registered nurse participants

Obtaining consent to participate in the study involved providing potential participants with detailed information about the purpose and intent of the study to ensure they entered into the research relationship with full knowledge and understanding of what their participation would entail. As the researcher, I did not participate in the consent process. An independent research assistant managed the recruitment process. The assistant worked within the hospital environment as a research nurse and was easily contactable, but had no direct involvement with the participants on a daily basis. I provided the research assistant with full information about the study and this individual was trained by me on all aspects of the consent procedure.

Potential participants were informed of the research through posters placed in communal areas in their work environment (Appendix B). These posters invited interested persons to contact the research assistant if they were interested in participating. Once contacted, the research assistant arranged to meet potential participants to answer any questions and to ensure the research process and study requirements were clear. At this time, she gave the nurse a consent and participant information form, which was returned to her once they had read and signed the consent form which signaled their intention to participate (Appendixes C & D). The research assistant had a good understanding of the research project and was able to confidentially answer any questions that arose throughout the consent process.

The signed consent forms remained with the research assistant and only five out of every six names of those who consented to participate were forwarded to me to
arrange an interview. To add clarity to this description, the selection process occurred in three stages. For each of the three stages, when six participants signed a consent form, the research assistant randomly selected five of these out of a folder, without looking at the participants’ names, leaving a sixth form behind. The sixth form was then transferred to a separate file. The research assistant continued to collect forms from interested participants for the next draw, and when six more signed consent forms were available, selection took place again as previously described. In the final selection, there were only three further interested participants, so the research assistant forwarded two names to me, making a sample of 12. To reiterate, a total of 15 staff consented to participate in this research; however, the total number of individuals who were selected and ultimately interviewed was 12 (table 1 p. 74).

The strategy of forwarding five out of every six names of consenting participants was adopted to ensure that I was never completely aware of who indicated an interest in participating and who did not. Additionally, it minimised any pressure the nurses in the department may have felt to participate. The participant information sheet clearly explained that, although an individual may have agreed to participate, there was a random chance that their name would not be forwarded. Once the recruitment and consent process was completed, I asked the research assistant to contact the nurses who expressed interest in participating but whose names were not forwarded to me, to thank them for their interest.
Table 1: Consent process

![Diagram showing the recruitment process with phases and numbers of participants]

**b. Gaining consent of prisoner-patients**

A further consent issue was that of involving the prisoner-patient in voluntary consent to be observed while registered nurses provided care for them in the post-anaesthetic area. I am aware that prisoners are a vulnerable population group and consequently sought to implement a valid consent process. I obtained their consent verbally, when they arrived in the operating suite. The hospital ethics committee agreed this was the only time that consent could be obtained, because transfer of
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prisoners from the prison to hospital was generally left to the last possible moment prior to surgery for security reasons. When the patient arrived in the pre-operative holding bay and prior to them receiving analgesia or mind altering drugs, I provided them with an information sheet that outlined the research and clearly stated they had the right to refuse being observed (Appendix E). After allowing time for the patient to read the information, I approached them again to reinforce that I was involved in a research project where I hoped to observe the care their assigned nurse gave in the recovery area. Again, I asked them whether they were willing to be observed and explained that, although the observation would indirectly involve them, it would have minimal, if any, impact on the care they received. No prisoner-patients refused to be involved.

Study design

My approach to the research valued each participant as a unique individual with experience and prejudices that contributed to their own understandings. After gaining the appropriate ethics committee approval (Appendix A), each participant was interviewed individually on two occasions, and observed while caring for prisoner-patients. In addition I also kept a reflexive journal.

a. Conversational interviews

Two conversational-style semi-structured interviews were conducted with each nurse participant. Although the terms ‘interview’ and ‘conversation’ can be used interchangeably, in the current research ‘conversation’ was used to describe a semi-structured, semi-formal exchange of information which enabled both the participant and the interviewer to share knowledge. An advantage of the conversational-style interview is that the subject matter determines the direction of the conversation, as well as the interviewer’s pre-understandings. As Weinsheimer (1985) suggested, “the object of the conversation is what both want to understand, and it is by reference to this object that they reach a mutual understanding. This joint object, not the partners, conducts the conversation” (p. 209). In the current research, conversation was stimulated with open-ended questions, although there was no defining order, and further direction was determined by the participant’s responses. Additionally, personal stories were shared by both the researcher and the participant to explore issues and develop understanding (Dearnley, 2005; Sorrell & Redmond, 1995).
The initial registered nurse interview occurred prior to observation of each nurse’s practice. The interviews were undertaken in a place that suited the participant and in their own time. Generally, they occurred in the workplace in a room allocated for this activity that assured privacy and avoided interruptions. The conversation was audio-taped and transcribed verbatim. I aimed to engage in an open and genuine dialogue and at the beginning of the interview; I reminded the participants that I would protect their privacy with masking techniques. Throughout I encouraged participants to include examples of situations to make the dialogue more real, reiterating I would mask any defining features of the story which might identify the prisoner-patient. At times, I asked the participant to explain something further or I asked a question to facilitate conversation, usually in the early part of the interview when I was trying to move the subject past general conversation. I also shared experiences that I remembered and, at times, the participant and I discussed situations at which we had both been present. An example of the types of questions used as probes were:

- Please describe your experience of caring for prisoner-patients.
- Thinking of caring for prisoner-patients, is there anything which might prevent you from caring for them how you might like?
- Can you share a situation where you felt your care of a prisoner-patient was less than optimal?
- Can you share a situation where you felt your care of a prisoner-patient was ideal?

Six to twelve months after the initial interview, I contacted the participants for a follow-up audio-taped interview, and again arranged at a time and place suitable to the participant. At the commencement of this interview, I brought the transcript of the first interview and suggestions of the preliminary prejudices that were evolving through my ongoing analysis of that participant’s understandings. I reiterated to the participants that the findings and suggestions of prejudices at this point in time were my early thoughts of their understandings and asked them if they rang true. Generally the participants concurred, and occasionally they offered a comment such as “did I really say that?” At no time did a participant verbalise any disagreement with any prejudices I identified. Additionally, each participant was given the opportunity to read the transcript of the first interview, but no participant desired to. The second interview enabled me to clarify issues that arose during the first conversation or during periods of observation.
The participants had time to reflect on the issues themselves and were receptive to deeper probing questions that enabled our understanding to develop. The second conversation with participants was also faithful to the notion of a hermeneutic circle, that of continually reflecting on the process, researcher influencing participant and participant influencing researcher (Crist & Tanner, 2003). It is “a second chance to make sure understanding has occurred” (Benner, 1994a, p. 107) and to continue to develop shared meanings or fusion of horizons.

During the data collection phase of this study two of the original 12 participants Sarah and Ryan left their employment at the hospital, Sarah to study and Ryan to travel. These decisions were made in the weeks following the first interview and I believed not enough time or experience had past to warrant a second interview prior to them leaving. The data obtained during the interviews was retained because with all participants it was the first interview which contributed the significant understandings, with the second interview strengthening and supporting the original data. The experiences and understandings discussed with Ryan and Sarah were valid, and contributed to the fusion of horizons. To not include this text, would result in lost data, potentially negating the integrity of the findings. I do acknowledge however, the lost opportunity to clarify meaning with these participants during a second interview.

b. Observation of registered nurse practice

I included observation of practice as an element of the research design, because it added an extra dimension to what participants said during interviews. I believed that the participants could have understandings and practices that were too much a part of their world to be recognised and discussed in interviews. I undertook a purely observational role in this phase of the research, which placed me outside of my usual practices as educator where I instructed, actively guided students and participated in the patients care. To make this point clear, generally when I am assessing or observing a student I work with them; however, in this instance I stood back and did not engage in any interactions with the participant throughout the time of my observation.

I observed registered nurse participants caring for prisoner-patients in the post-anaesthetic care area during the six to twelve month break between the initial and second interview. The observations were organised on a daily basis once the operating theatre patient schedule and staff roster for the day was finalised, but
only occurred on the days that prisoner-patients were scheduled for surgery. The holding-bay nurse who supervised the area where patients waited for surgery contacted me once a prisoner-patient arrived in the area. I spoke to the prisoner-patient and offered them a written information sheet as discussed previously. Once the prisoner-patient consented to participate, I went to the post-anaesthetic care area to ascertain if any nurses were available who were participating in the research. This co-ordination was difficult – the nurse needed to be waiting with no other patient in their care when the prisoner-patient arrived in the post-anaesthetic care area. Each nurse was observed between three and five occasions over a period of several months. The observation period lasted for the time the prisoner-patient was in the post-anaesthetic care area, which was a minimum of thirty minutes but generally at least one hour. During the observation process, I took field notes where I wrote down observations, conversations and general impressions of aspects such as gestures and facial expressions. These were later that day typed and stored digitally on a password-secure computer, with the hard copy being kept in a locked filing cabinet when not in use.

Repeat observations were necessary to enable me to reflect on the information the participant discussed during the interview about their caring practices for prisoner-patients and to determine whether the actual care they provided reflected their self-reported care. The repeated observations were also an attempt to address the participant’s potential for being self-conscious during the observation period.

c. Journalling

Some authors claim there is a lack of evidence to substantiate that self-reflection, pre-understandings and perspectives influence the research process (Burke Draucker, 1999; Koch, 1996; Koch & Harrington, 1998). In order to identify and convey my pre-understandings and to keep faithful to the notion of the hermeneutic circle, I maintained a reflexive journal for a total of two years, from six months before data collection commenced, throughout the period of data collection and until its conclusion.

Keeping a journal throughout the entirety of the data collection required a great deal of discipline. The information on my early understandings about the experience of caring for prisoner-patients was beneficial, but I was often not able to see that at the time of writing. However, the importance of my early ideas became increasingly apparent as my research progressed. My intermittent entries into my
diary revealed my thoughts and opinions about the relevant aspects of the research process. I also utilised my journal as a notebook in which I outlined ideas or plans as they came to me and noted the titles of books or summaries of articles recommended from a variety of sources. I kept minutes of meetings with my supervisor, my time plan and occasional notes taken during seminars. As the research process progressed, I went back over my notations and re-read them, writing further comments in my journal about how I had changed, or about things in the interview process that had surprised me.

The process of journalling also necessitated an active critical thinking process to move past my assumptions about the experience of caring for prisoner-patients and be open to what others had to offer. Within a hermeneutic phenomenological philosophy, openness or Bildung is required throughout the process of data analysis. Maintaining a journal is only one element of the process of reflection, if it is not something that reveals greater understandings then the process has little merit. Taylor (2006) suggested the skills required to facilitate critical thought with journaling include, intellectual humility, perseverance and integrity. Evidence of this process can be identified within the Gadamerian framework of the study by the manner in which my early thoughts or prejudices on the experience of caring for prisoner-patients were altered as I became immersed and critically reflected on the participants’ horizons, a process which culminated with the development of fused horizons.

Processes of data analysis

For Gadamer, there is no one truth or one common understanding. Gadamer made it clear that understanding occurs as a result of a fusion of horizons between the interpreter and the text. Each person who interprets a text brings their own pre-understandings and prejudices that influence their interpretation and hence understanding. The process of data analysis utilised the Turner (2003) method, which is based on Gadamer’s principles of understanding. The process involved identifying my own prejudices and horizons about the experience of caring for prisoner-patients utilising the reflective journal I kept. From the interview transcripts, I identified the participants’ prejudices and horizons, and finally merged these experiences into several fused horizons or experiences which rang true for all the participants, myself included (table 2: p. 83). Finally I developed a statement
that expressed the phenomenon of caring for prisoner-patients, for the participants of this study (table 3: p. 179)

The first phase of the analytic process was to identify my own prejudices and horizons. I read my reflective journal and asked myself ‘What do I really think about the experience of caring for prisoner-patients?’ I utilised the text in my journal in a similar way to the text that evolved from the interviews. I read and re-read passages, looking for key ideas and asking myself what it was I really thought. I identified numerous prejudices, which I listed. I did this at the commencement of data collection, I wanted to have a record of my understandings at the beginning of the interview process, so I could reflect back and see whether my thinking changed.

The interviews were audio-recorded and transcribed verbatim. As I transcribed the data, I listened many times to the verbal recordings. I made notes that included added detail such as ‘long pause’ and ‘laughter’. Once each individual interview was transcribed, I listened to the audio recordings again while I read the transcript. At this time, I highlighted any sentences or words that I did not understand and I went back to the participants and asked them to clarify what they meant. For example, one participant used the word ‘dominant,’ which did not make sense in the context of the sentence. When I asked her to re-read the comment, she said ‘oh I meant to say subservient’. Another participant used the word ‘clong’ I had to ask her ‘what does clong mean?’ to which she replied ‘to hit me’. Once the majority of first interviews were completed and transcribed, I continued with the analysis process utilising the Turner method.

I then read and re-read the transcripts also following Benner’s (1994) suggestion that, with each reading, I pause, think deeply and ask myself “What do I know now that I did not before reading the text?” With each reading, understandings emerged that I considered deeply. To reinforce this, at the top of each page I wrote myself a note ‘What is Andrew (for example) trying to tell me?’ The process took a considerable amount of time and continued until I was confident that I had a thorough understanding of what the participant was saying about the experience of caring for prisoner-patients. I made comments and notes to myself on the transcripts, highlighting phrases that occurred repeatedly, noting similarities and differences. I followed the path of the hermeneutic circle by examining the transcripts as parts and whole. I looked at phrases and words then went back and
read the entire transcript before focusing again on a single phrase. Early on in this process I met with the participants for the second interview. At this time I shared my early understandings with the participants to see if my identification of their key thoughts or prejudices, although preliminary, struck a chord with them and what they were trying to convey.

Through this process, and in keeping with Gadamerian concepts, I eventually developed prejudices for each of the participants. Each prejudice was a phrase, in the participant’s own words, which I felt captured a part of the experience of caring for prisoner-patients. At times individual participants’ prejudices appeared to contradict each other, such as “I just want to get rid of them” and “you’ve got to care”. These contradictions highlighted the layers of complexity and mixed emotions the participants expressed about their experience of caring for prisoner-patients. I examined each participant’s prejudices as a group, to identify horizons or statements that described the totality of their experience. Again, I moved between the parts and whole, examining prejudices and moving from prejudice to the transcript to ensure I had captured the experience accurately. When returning to the transcript, I used a highlighter to identify each section of the dialogue that I had previously considered. This technique revealed remaining text and ensured I had not missed significant aspects of the participant’s experience. Generally, what remained were repetitive statements.

I reconsidered my ideas and understandings about the participant’s point of view to determine the similarities and differences between their understandings and my own, in an effort to fuse our horizons. A dynamic between prejudice and horizon evolved each time I considered the text, and I developed horizons or statements that captured the experience for the participant. Unlike prejudices, horizons were expressed in my own words and were followed by an explanation about why I considered them to be trustworthy summations of the participant’s experiences. I identified horizons and fused horizons by listing each participant’s prejudices on a large piece of paper and drawing a mind map with colours and lines demonstrating the connections between experiences.

Developing fused horizons did not imply that all parties agreed about an experience. Rather, it acknowledged elements of the experience that were important for each participant, even if these elements were diametrically opposed. For example, when participants discussed the relevance of a prisoner’s crime to
the delivery of nursing care, all points on the continuum from believing it was extremely important to it being totally irrelevant were considered under the same fused horizon.

Every experience was valid, so each prejudice contributed to a horizon and each horizon contributed to a fused horizon. Once developed, prejudices were not ignored, no matter how contradictory or unique. When situations developed where a prejudice or a horizon stood alone, I went back to the beginning and reconsidered my decisions, as this meant I had not yet truly captured the experience. The final point of the analysis process was to develop a succinct statement that expressed the experience of caring for prisoner-patients by this group of participants. This statement did not negate the multiple experiences of the participants but rather sought to add a deeper level of understanding.

Turner’s method of analysis and thematic analysis are similar, but also different. Turner’s (2003) process does not move data to higher levels of abstraction in a deductive manner; rather, it fused in an inductive manner multiple thoughts and realities between the participants and myself, including where they intersected and where they contrasted. It allowed all manner of ideas and experiences to be identified without the necessity of streamlining a person’s experience and excluding pieces of the puzzle that did not seem to fit.
Ethical considerations

Several issues relating to the ethics of the project were considered. Prior to commencing the study, approval from the Deakin University Human Research Ethics Committee and the hospital ethics committee was sought and obtained (Appendix A). The principles of beneficence (do good) and non-maleficence (do no harm) are imperative to any research process and are integral to the current research. Overall, the ethical principles employed in the study were; having respect
for my colleagues; honouring the participants’ voice; and valuing their agreement to participate.

**Beneficence**

The research has been beneficial in several ways. First, participants were invited to tell their stories and experiences of caring for prisoner-patients. It has empowered and invigorated registered nurse participants to talk about situations in their clinical practice where they felt they made a difference in someone’s life. Further, participants were given the opportunity to discuss something that is rarely addressed, that of giving nursing care to prisoner-patients. Through developing increased awareness of the uniqueness of this particular nurse–patient relationship some participants expressed that they developed greater clarity regarding their care-giving practices. Potentially, the findings of this study could be used to inform understanding by the wider nursing community of the complexity of this role.

**Non-maleficence**

It was not anticipated that the interview and observation process would be stressful for the participants, as the research methods employed (interviews and observations of practice) were conversational and relaxed in style. It was reinforced to the participants that they could have directed the conversation away from areas that they found uncomfortable, that I was not seeking right or wrong answers but, rather, was providing a forum in which they could reflect on their own experiences. The participants were also reminded that the interview transcripts were de-identified following the completion of the research process. The participants had the knowledge that, at any time they requested, they could withdraw from the process, including mid-interview or during observations of practice.

The observation process had the potential to be confronting, but participants were fully aware of what the research project involved prior to consent being obtained. Many of the participants have had the experience of being observed by me in the past and as such were able to make an informed choice to be involved, knowing how they might feel about being observed. To assist the participant to be comfortable throughout the observation periods, I offered to suspend my observations if it was considered by the participant or myself that the patient’s or their own wellbeing was compromised.
Another issue that could have been potentially stressful to the participant is that the interview/observation process could have identified gaps in the nurse’s practices or surface ideas about situations where they felt they could have done something better but lacked the maturity, time or resources to do so. This could have given rise to verbalisations of regret or stress. Careful consideration was given to stressful outcomes and, if stress reactions occurred during the interview or observation, it would have been immediately suspended until such a time that the participant indicated they were ready to resume. In the event the participant did not wish to resume, for any reason whatsoever, they could withdraw from the study without penalty and all data collected up to that point would not have been used. Additionally, participants had access at no personal cost to the hospital-based counseling service should it have been required. However, issues related to participant stress did not at any time arise during the conduct of this research.

Coercion and power

As I had well established relationships within the practice and research environment, a consent process was established that aimed to protect the potential participants from any undue pressure to participate in this research. This process was outlined earlier in the chapter and resulted in myself never being fully aware whether a colleague whom I did not interview agreed to participate, but had their name withheld, or did not wish to participate. Power imbalance is a consideration in all research environments and is particularly significant to this research as my normal role is at a management education level. Power imbalance has been addressed exceptionally well by feminist researchers and is a hallmark of feminist methodologies. As Tang (2002) suggested, feminists emphasise the multilayered and dynamic nature of power in research, in particular, power imbalances. What I embraced within this project from this valuable feminist contribution was a focus on strategies that minimised power inequalities as far as possible. For example, I used several proactive strategies to address power imbalance, such as the adoption of a Gadamerian philosophical framework which has at its heart the joint collaboration between participant and researcher as understanding is sought, and an unstructured interview style to encourage open and honest conversation.

Marx (2001) suggested that honesty and reciprocity are necessary to build a rapport and at all stages in the process I sought to be open and honest with the participants regarding what motivated me to undertake the study. Further, the
research design had at its focus a conversational-style two-way exchange of information, allowing participants to raise concerns and ask questions. Benner (1994b) recommended that one way to address power issues was to encourage the participant to disagree with the researcher; this occurred as our conversations allowed open discussion. The confidentiality and consent process was also an attempt to negate coercion by masking which nurses in the post-anaesthetic care areas agreed to participate thus reducing the pressure. Finally, and of significance, is the value of reflexivity or critically evaluating assumptions that underpinned my understanding. The use of reflexivity was an ongoing process throughout the research, as previously discussed, and using this strategy heightened my awareness of the will to engage in open and transparent communication process with participants.

**Witnessing unsafe practice**

In the context of observing participants’ nursing care of prisoners, it was possible that I would witness as a researcher behaviour or care as an educator that I considered to be unsafe or inappropriate. As a nurse educator of six years’ experience, I am qualified to recognise these types of situations and have, within the context of my role, previously dealt with several situations where I needed to address poor practice. Therefore, I developed strategies on how to handle such situations prior to engaging in the observation process with the participants. My research plan included a commitment to speaking with the participant regarding the issue in a non-threatening, confidential manner, offering education and support as required. At the time that an unsafe practice was identified, I would have ensured patient safety as paramount and intervened accordingly, the observation process would have been suspended and support would have been given to the nurse and patient, through the normal hospital counseling process, with observation only recommencing at a later date if the participant chose to continue in the research project. Fortunately, throughout this research I did not witness any unsafe practice.

**Trustworthiness of the study method**

Rolfe (2006) considered that wise judgement and keen insight of the reader is responsible for interpreting the trustworthiness of the research. For Gadamer, truth is ongoing and subject to individual interpretation and is found in the details of the process (Gadamer, 2004). To ensure the findings of this study were trustworthy and a truthful representation of the experience, I have made the details of the
research process explicit creating a clear audit trail. In the study findings, there are excerpts of participants’ dialogue so that if a reader does not agree with the conclusions drawn, they will be able to follow the pathway that was used to reach such conclusions. I embraced and respected the participants’ voice throughout the research process. One way in which I sought to clarify the participants’ voices and experiences was through the second interview with each participant and the observation of practice. This allowed for clarification of thoughts and gave the participant another opportunity to express their understandings. The research journal and active reflection enabled me to monitor and clearly describe the research process, which will be portrayed in the findings and discussion chapters. In addition to a respect for the participants’ voice, I valued the ethical principles of respect and truthfulness in all aspects of this study. I hold a deep-seated appreciation for the honesty with which the participants spoke of their experiences and have endeavoured to do justice to their faith in the process.

**Researcher influence**

For Gadamer (2004), understanding occurs through a joint process between those seeking to understand. Within this premise, both the researcher and the participant influence the outcome of the process and contribute to understanding the phenomenon being explored. I do not consider my experiences as something to negate, nor have I attempted to remove myself from the immediacy of understanding. In fact, I welcomed the position from which I approached this project, as it was in part responsible for the development of a deep yearning to make fully significant understand the phenomenon of caring for prisoner-patients. I acknowledge my own influence or understanding of the complex process of registered nurses caring for prisoner-patients but I do not hold my own understanding in a place of supremacy. Throughout the research process; I maintained an attitude of *Bildung* or being open to meaning, particularly being open to meaning that was other than my own.

**Strength and limitations of the research**

There are some strengths and limitations to this study. The hospital environment where the study was undertaken highlighted the experience of providing nursing care for prisoner-patients in a unique way as the post-anaesthetic care area receives 1–2 prisoner-patients per day. This offered a group of nurses who participated in this research, unique understandings of this experience which are
distinctly different from experiences of nurses who have isolated exposure to
prisoner-patients in an acute setting. The length of time a patient spends in the
post-anaesthetic care area is another point for consideration, and one that could be
perceived as a limitation. The minimum amount of time spent in the post-
anaesthetic care area could be as short as 30 minutes, however 1–2 hours is more
likely.

Fundamentally, questions could be raised regarding whether any nurse could
engage in authentic caring for any patient, much less a prisoner-patient in such a
short space of time. In the post-anaesthetic environment the care is generally
delivered at a 1:1 ratio. Experientially I suggest the intense nature of caring in this
environment usually makes the connection a significant one. Patients generally
spend one hour, but often two-three hours in the post-anaesthetic care unit which
in terms of contact time is comparable with the two hours 19 minutes a ward nurse
was found to spend with a patient over three consecutive shifts (Lotzkar & Bottorff,
2001). It is not just the quantity of time nurses engage with a patient but also the
quality of the interaction that is significant. This is an element of the relationship
that has as much to do with the character of the nurse as it does the environment
whether that be the oncology ward or the post anaesthetic care unit and is an area
this study will seek to explore.

While it is true that the findings from this study are not generalisable, they are
significant in that they authentically reflect the concerns of the participants who
engaged in this research. Also although I do not claim generalisability of the study
findings, I can say that in the multiple forums in which I presented the tentative
study findings I noted the collective assent of those who attended and strongly
agreed that the study findings mirrored their realities and experiences.

In addition the participant group contained only two males, which reflected the
overall gender balance in nursing, but which restricts inferences that could be
drawn on the basis of gender. The nature of the data obtained was influenced by
my position of insider, an issue which is considered further in the discussion
chapter. Finally, in this research the prisoner-patients’ views were not explored,
and I acknowledge that exploration of this dimension could further add to our
understanding of the caring dynamic between nurses and prisoner-patients.
Chapter summary

In the research, I was not striving to maintain a stance of objectivity; rather, my goal was to achieve a mutual sharing of information, impressions and opinions about the phenomenon of registered nurse care for prisoner-patients. Sharing experiences with the participants expanded and developed my own understanding of the experience of caring for prisoner-patients and enabled me to explore some of the unique and mutual horizons held by this group of nurses. Increasingly within the literature, there is an appreciation that the researcher influences the environment they are studying. In this research the effect of such influence was recorded and examined through the reflective process of journalling.

The philosophical framework for the research was Gadamerian hermeneutic phenomenology. In this chapter, I described the relationship between the philosophical basis that guided this research and the practical processes of undertaking the journey of understanding. The journey entailed repeated conversational-style interviews which probed and explored the experience of caring for prisoner-patients in an acute environment of the post-anaesthetic care area. The interviews were supported and reinforced by direct observation of the nurses caring for a prisoner-patient in the post-anaesthetic care area and, finally, through the process of reflection and journalling. The analytical process and the hermeneutic circle and its relationship to Gadamerian philosophy were outlined. I also explored the ethical foundation upon which the research was based, in particular, those issues resulting from my familiarity with the research environment. Finally, I discussed the means I used to ensure transparency throughout the research process. In the next chapter I present the study findings.
Chapter Five:

Findings
Horizons revealed

Introduction

In keeping with Gadamerian ideas of understanding, I present the findings of this study through the explication of the prejudices and horizons of each participant. I begin this chapter by describing my own prejudices about the experience of caring for prisoner-patients, which was the starting point for my exploration of this complex phenomenon. My prejudices were extracted from my reflective journal, and they give insight into my early thoughts about the experience of caring for prisoner-patients. In ‘horizons revealed’, the twelve participants’ prejudices are then presented to convey their thoughts on what it was like for them to care for prisoner-patients. The prejudices presented are the dominant and recurring thoughts that emerged through analysis of the dialogue as I dwelt on each participant’s experiences and these are supported by the inclusion of extracts from the participant’s interview transcripts. Immediately following the presentation of each participant’s prejudices, I reveal the participants’ horizons, which I developed following deep reflection on the dialogue and which encapsulate what the participants expressed about the experience of caring for prisoner-patients. I used bold type to indicate the participants’ horizons to indicate the particular importance and to draw the reader’s attention.

In ‘fused horizons’, the study findings continue as I weave the individual participants’ horizons to create a fusion of ideas which, when considered together, convey the complex phenomenon of registered nurse caring for prisoner-patients within an acute care context. I conclude the chapter with a succinct statement that identifies what it was like for the participants of this study to care for prisoner-patients.

Revealing my own prejudices or pre-understandings

I have ten years’ experience working in the perioperative environment and caring for prisoner-patients. Over the time of my immersion in this practice area, I observed that caring for prisoner-patients appeared to be enacted differently by registered nurses, when compared to other patients. Although I had my own ideas to draw on to understand this, what I saw and heard puzzled me. For instance, when I discussed my observations with colleagues, they were quick to point out that prisoners were ‘just like any other patient’ and hence they were ‘treated the
Findings:

same way’. However, this assertion did not match my observations, which were that nurses, including myself, spent minimal time with and had limited interaction with prisoner-patients. I wondered if I was the only person who, when caring for prisoner-patients, was consciously aware that prisoners were cared for by me from what I concluded through examining my journal entries, was a lofty position. I also questioned my ability to give good nursing care. It is out of this curiosity that the study emerged, as can be seen from the following notation in my journal:

My assumptions at the beginning of this project are that we treat prisoners differently and that they are different, a unique cultural entity. I am surprised that not many of my colleagues agree that we treat them differently. The overwhelming perception is that they are all treated the same… It is my view that prisoners constitute a unique patient group with their own unique care issues, many of which are challenging for nurses.

I further identified that:

The claim by nurses and other medical professionals who report that their treatment of prisoners is ‘no different’ from any other patient is not supported by my direct observation of their caring.

The more I thought about my feelings and observations, the more questions were raised for me about the expectations that we bring to our practice and how this affects us as nurses. For example, I wrote:

Prisoners have very specific identifiable characteristics as a population group that may influence the nurse’s impression of the individual patient… I wonder is it possible to build a significant nurse–patient relationship with prisoner-patients within the perioperative environment?

As I absorbed myself in this study and reviewed literature about notions of caring for and caring about prisoner-patients, my curiosity about the phenomenon of caring for prisoner-patients deepened. My journal reflected a belief that there were significant demands placed on nurses by these prisoner-patients when caring for them. Further, in my workplace, there was a tacit yet rarely voiced expectation that nurses would altruistically and authentically care for these patients, as is suggested by our hospital mission statement. The hospital values are embedded in a history of caring for prisoners and disenfranchised individuals regardless of their circumstances; what the patient may or may not have done prior to their admission and how they treat the nurses who provide care for them. Within this hospital, nurses are expected to provide care for patients in any situation and while I agree
with this sentiment my curiosity was piqued regarding the realities of caring for prisoner-patients in the peri-operative environment.

I dwelt on this and wrote in my reflective diary:

*Descriptions of caring in a nursing context are often idealised notions that do not reflect the reality of practice, particularly as it relates to the care of prisoner-patients. Further, there is a lack of literature regarding situations whereby caring is difficult or demanding on the nurse and very little is written about the emotional impact of caring for prisoners in any situation. I am interested in exploring the nursing assumption that we have to care about all patients, prisoners included, to be considered a good nurse and I do not like being told what I have to do.*

For some time I have been familiar with the work of Arlie Hochschild (1983) and the concept of emotional labour, defined as the emotion work that is an expected part of many of the caring professions. It is well known that nursing is a profession that is sometimes demanding and which drains nurses on an emotional level. I spent time pondering Hochschild's ideas, in particular with regard to my care of prisoner-patients. In my journal, I elaborated:

*Some days I feel like a smile is plastered on my face. Some days I don’t feel like being kind or nice… At the end of a day, I sometimes get home and don’t feel like being nice or chatting to my family. I feel all used up. I wonder, is it right that I get used up at work?*

I also considered whether knowing the crime the prisoner committed made a difference to the care that they were given by nurses. As my journal suggested:

*It is interesting to see what people's reactions are when they know the prisoner, and what they have done. Notions of celebrity are very apparent in their reactions to some of the prisoners. I play a game with myself whenever I am caring for prisoners. I pretend they are in jail for not paying parking fines. In that way, I allow myself to engage with them... if you know what they did, you cannot play the game and often you cannot engage.*

Additionally, I wrote:

*I always have a niggleing thought that I cannot suppress, which asks, ‘I wonder what they did?’*

When reading the reflections in my journal, I identified that my prejudices were not only evident, but also permeated the enactment of my role and my understanding of what it meant to me to care for prisoner-patients. To deepen my understanding
of this complex phenomenon, I dwelt on my prejudices, which enabled horizons to surface that encapsulated my experiences of what it was like to care for prisoner-patients.

The five horizons I identified were that:

- all nurses would care for prisoner-patients differently from others;
- there was an incongruence between the philosophical assumptions upon which caring is based and the reality of practice;
- the characteristics of prisoner-patients set them apart from other patients, therefore making nursing these patients difficult;
- nurses faced a dilemma in caring for prisoner-patients that placed them in the chasm of custody vs. care; and
- nurses are reluctant to admit that caring for prisoners is hard and present themselves as the ‘good nurse’ regardless of how they feel about their situation.

It is a foregone conclusion that my horizons, although legitimate, are not the exclusive avenues to truth about the complexity of caring for prisoner-patients. I found this experience to be compelling and there were many things that I wanted to explore further with other nurses, to better understand this phenomenon. Thus, although I went into interviews with embedded assumptions or horizons that typified my own understandings, I also maintained a commitment to remaining open to what I would learn, and how this would re-shape my understanding of this phenomenon. I wanted to explore this experience on different levels of abstraction as well as practical realities of caring for this group of patients and to know intimately what it was like for other nurses to care for prisoner-patients. My quest for understanding went beyond what I began to regard as the rhetoric of care – that is, I wondered if nurses who cared for this patient population within an acute care environment cared for them indiscriminately and unconditionally, as the mission statement of our hospital required. Through analysis of the data, I gleaned aspects of caring for prisoner-patients that I had not previously considered. I will now outline the prejudice and horizons that emerged through analysis of the dialogue of the 12 participants.
Andrew

Andrew commenced his employment in the recovery unit over six years ago as a graduate nurse. In the time since, I observed him develop and refine his nursing skills. He obtained a postgraduate diploma in advanced nursing, focusing on perioperative nursing, which required an additional year of study at university. Colleagues agreed that Andrew was the nurse whom others looked to for support in the recovery environment, especially when a particularly aggressive or well known prisoner-patient presented for care. In his dialogue, Andrew expressed a strong will and desire to be a ‘good nurse’ and to ‘do the right thing’ by his patients. Many of Andrew’s statements were prefaced by the phrase ‘I try’ and this trying was important to him; he actively and consciously worked at doing his job well.

Andrew’s thoughts were revealed through the following six interwoven prejudices:

• I try not to judge;
• Prisoners require more pain relief;
• You get used to it;
• Just because a dog has a lead doesn’t mean it won’t bite you;
• I try to keep a routine; and
• They are entitled but…

I try not to judge

For Andrew, being non-judgemental about prisoner-patients was important. His dialogue revealed a strong conundrum when providing care for prisoner-patients. He asserted that fairness and equality of care was an ideal position from which to care for prisoner-patients. As he expressed it:

*I make a conscious effort to treat them as I would anyone else. I think that’s important... I try to think the only difference between this patient and another patient is that they’ve been caught<participant emphasis> for what they’ve done. There may be another patient who’s done exactly the same crime, but has never been caught for it, and you would never know. I keep saying in my head ‘it’s not for me to judge this person’ which is what I do with prisoners; with some I just reiterate it a lot more.*
On the other hand, he suggested that caring for these patients was conflict laden and clearly he struggled. He admitted that knowing what the prisoner did interfere with his intention to deliver non-judgemental, egalitarian care. Hence, the value positions from which he liked to care for patients were challenged by the reality of his situation. In his words:

*I try not to find out [their crime] before... I don’t seek it out... it does help if you don’t know. Although I might have a philosophy of trying to take care of a patient like anyone else, I’d rather not have that challenge [of knowing] on me, challenging my values. If you don’t have it, it is a lot easier to just get on with the job, whereas if you do know, then you are challenged. Knowing what they have done beforehand, throws up a lot of debate in your mind... it can affect the way you want [participant emphasis] to look after the patient. I think it’s better not to know, because then at least you can go in and be non-judgemental... for me, I sort of go ‘oh, prisoner, convicted of something – move on.’ It’s not that you don’t think about it, you just move on... If you sort of say, ‘prisoner, shot three people in the street, one died, this was yesterday’, then it conjures up a whole lot more in your mind.*

In the course of sharing his ideas with me about caring for prisoner-patients, there was an episode that Andrew remembered as difficult and deeply confronting. He frankly admitted that he did not want to look after a particular prisoner-patient because of the crime they committed and his nursing care fell short of his ideal. He said that he took care of the patient but he didn’t care for the patient. This was a subtle but important distinction.

*A patient was awaiting trial for terrorism charges... I did find it quite difficult to look after this patient because I knew the story... and I just didn’t feel like I wanted to look after that person because of that. I did find it quite difficult to overcome... I was still able to implement everything, but I thought ‘I’m having trouble looking after this person’.*

Later Andrew expressed similar sentiments when he relayed a different example. He said:

*I let it bother me more than I would any other sort of case. It [care of the patient] was a challenge... I tried not to think about it too much,... push it out of my mind initially just so I could care for him, ... but certainly afterwards when it was over I thought about it more.*
I asked him if he thought that it was easy, to be non-judgemental. He replied:

_No, no it’s not. I guess I just try not to think about what they’ve done. It is not an easy thing to do, but I guess I try to treat them like any other patient... I try to be non-judgemental; it’s probably the hardest thing._

There was a voyeuristic aspect to Andrew’s experience. He explained:

_I think part of it is a voyeuristic type thing as well. You want <participant emphasis> to know… it’s kind of a novel thing. You might recognise the face or the name looks familiar and you think, ‘have I seen them in the paper or news’? People look it up on the internet just to see what sort of response comes up. I don’t think that’s necessarily a good thing._

And later Andrew elaborated:

_It is a lot easier to find out what these people have done with the advent of the internet and everything and people do that. It’s not a good thing to do, as it changes your perception a lot._

As Andrew verbalised, his experiences of caring for prisoner-patients were permeated with what I came to regard as ‘mini conflicts’. On one hand, he tried not to think about things too much, and yet certain experiences affected him deeply. Andrew spoke about his efforts not to judge prisoner-patients, yet in another breath he also voiced a voyeuristic tendency when he encountered a prisoner-patient. Through his dialogue Andrew revealed that, on one hand, he would rather not know what a prisoner-patient had done, because not knowing enabled him to ‘just get on with the job’. However, on the other hand, without directly including himself, he revealed that ‘people’ used the Internet as a means of discovering knowledge about the crime a prisoner had committed. These layers upon layers of experiences and conflicting thoughts are evident throughout Andrew’s story.

**Prisoners require more pain relief**

While Andrew tried to treat prisoner-patients in the same manner as any other patient, he did acknowledge that one area where he changed his practice was with regard to analgesia delivery. He implied that some nurses felt prisoners asked for analgesia as part of duplicitous act to obtain narcotics; whereas Andrew suggested that he was experienced enough to realise that and capable of assessing those in genuine need.
Findings:

Andrew explained:

*I guess I do treat them differently, particularly given the demographic. A lot of them are ex. or current IV [intra-venous] drug users and they quite often will require a lot more pain relief... and I guess in that respect I do treat [prisoner-patients] differently to, say, someone who had the same procedure who wasn’t opiate tolerant. I do try and not discriminate against them because they are IV drug users, and assume they are just doing it because they are getting high; whereas in actual fact, more often than not, they just have a high tolerance and they need more.*

He later continued:

*It does happen very occasionally that you are able to sort of work out whether it’s pain (or) medication seeking behaviour, which does happen. Like the patient obs [observations] might be completely stable and they’re saying ‘oh I’ve got pain’. Maybe it’s not appropriate to give them pain relief in that respect. I do notice it sometimes on the nursing side, that they may be reluctant to give pain relief for that reason. They think the prisoner is just seeking medication.*

Andrew’s dialogue provided some insights into the complexity of providing analgesia for prisoner-patients. What is interesting were his comments about what other nurses do; other nurses are reluctant to give pain relief. Andrew asserted that he had the experience to know what to do in this situation, Andrew referred to his experience several times, which will be seen in the next prejudice, ‘You get used to it’.

**You get used to it**

In many examples, Andrew compared his early feelings about caring for prisoner-patients to later experiences. As contained within the previous dialogue, Andrew asserted that, over time, he gained confidence and based his care on an experience-centred approach. He said:

*Initially it can be quite confronting, but again, after working here six and a bit years you get used to it, because we have so many prisoner-patients going through. I suppose for me I’m fairly used to it, because I’ve been doing it for so long. Initially I approached it with a bit of caution, because you don’t really know what they’re like. I guess it’s the fear of the unknown, but having worked with them for a few years... I don’t have too many problems with them.*
Further in the conversation he added:

Nowadays I’m a bit less wary of the patients who are prisoners, because more often than not, I find they are no trouble.

Even though familiarity shaped Andrew’s care, it was not the whole story. Andrew continued to mention confronting experiences and times when he felt he needed to alter his practice. As Andrew explained:

We have two guards come down [to theatre] with most prisoners. But, say, if for some reason you’ve got guards and federal police officers, and you’ve got a prisoner who is shackled hands and feet, you do seem to feel like you did on that first day, because it’s different than we ordinarily have.

Careful attention to Andrew’s dialogue revealed that Andrew became less wary over time and generally cared for prisoner-patients without incident. But what was noticeably absent was any discussion regarding the prisoner-patient as a person or any mention of the relationship he might develop with a prisoner-patient.

**Just because a dog has a lead doesn’t mean it won’t bite you**

Despite advocating a non-judgemental approach and claiming he was increasingly confident with experience, Andrew described that he used a cautious approach when interacting with prisoner-patients. This wariness was not because of personal experiences, as no significant events had happened to Andrew directly. Certainly, in the time of Andrew’s employment, prisoners had attempted to escape and, in one instance, a prisoner was shot and killed by a guard. Within the unit, there is a significant amount of folklore surrounding the history of prisoners at the hospital, with exaggeration of the worst stories. For example, a prisoner was choking a guard with his handcuffs and the anaesthetist literally threw, a syringe full of a paralysing drug, like a dart into the prisoner-patient’s leg, causing the prisoner to collapse. This historical influence, the story telling, and fear of what might occur in the future, possibly resulted in Andrew adopting a cautious approach to prisoner-patients. Andrew began his story with:

Initially I approached it [care of prisoner-patients] with a bit of caution, because you don’t really know what they’re like and I guess that’s the fear of the unknown.
There was an underlying feeling of unease that Andrew expressed:

I think it’s always there... I’ve never had a problem with a prisoner getting up and running away, but at the same time, it’s always been at the back of my mind... ‘oh no, this isn’t safe, this isn’t right’... stuff has happened here in the past... where people have been hurt, who’s to say it’s not going to happen again?

Andrew mentioned handcuffs as a part of the experience of caring for prisoner-patients and reflected:

I suppose initially I would be a bit reluctant to take the handcuffs off... it’s like saying, just because a dog’s got a lead, it’s not going to bite you.

Andrew placed little confidence in the guard’s ability to provide safety within the perioperative environment. He said:

If this person did decide to run away, or should decide to harm someone for whatever reason, I don’t think they [guards] are going to be any use here at all... that’s made me feel really uncomfortable.

Andrew’s dialogue revealed that he drew on his experience, caring for prisoner-patients to help him deliver non-discriminatory care. He also revealed that the experiences he gained over time enabled him to get ‘used to’ caring for prisoner-patients. Yet, he was always cautious and mindful that past events could happen again and his metaphor ‘just because a dog’s got a lead it’s not going to bite you’ revealed that he was wary and watchful when caring for prisoner-patients, particularly as he felt that, if something happened, he could not rely on the guards for assistance. Hence, Andrew’s conversation was peppered with references to his practice of keeping to routines and not thinking about things too much.

I try to keep a routine

Andrew found solace in focusing on routine aspects while providing nursing care for prisoner-patients. With this focus, Andrew was able to separate his caring activities as he mentioned previously, ‘implementing things’ from having a caring attitude. I considered this a subtle but pervasive way in which caring for prisoner-patients was different from caring for other patients.
Andrew explained:

I really just try to think about the job that I have to do for people. There is a lot of routine involved, you do this, then you do that, and then you do the next bit, so I try to think about those things... that is the main thing, just trying to keep a routine more than anything so you don't think about it too much, about what they've done. That doesn't mean to say that you don't, you just try not to let it interfere with it all. Yeah, I guess I try not to get too involved with them.

Andrew elaborated on the separation of care from caring when he said:

You might go through all the process of looking after the patient, the actual physical activity of looking after them. OK they need this drug, you give them this drug, they need their dressing changed OK you do that. Do it all, all the clinical component to your care, but you know, whether it's done in the same fashion as Florence Nightingale mopping their brow, saying a prayer for them, it might not be the same way... not maintaining that empathy, not always.

Another aspect of routine care Andrew described was reduced engagement with a prisoner-patient; he explained:

I don't really want to engage in conversation because there's a good chance it might irritate them. It would irritate me if I was in prison and someone was asking how was my weekend? You don't want to upset them.

The discussion of care added a layer to Andrew’s experience that began to reveal the complexities involved. Andrew cared for prisoners differently, despite having the desire to be non-judgemental and actively seeking to be a good nurse. His care was entrenched in following routines and not thinking; yet he believed that prisoner-patients were entitled to certain rights and adequate health care.

They are entitled but...

One of Andrews' belief structures, on which he based his nursing care, was that everyone is entitled to adequate health care. Andrew said:

Sometimes I think everybody makes mistakes and we are still entitled to certain rights with adequate health care... we live in a country where adequate health care is available. Just because you're in prison doesn't mean you should be denied those privileges.
Andrew mentioned an example where his belief in an individual’s entitlement was challenged, as he relayed a story about a prisoner-patient who had harmed himself after being arrested for a terrible crime. He said:

_They’re entitled to their medical care, whereas this guy was there because he’d injured himself, to stop going into the general prison population straight off the bat. I thought that was a bit unfair… I did find a lot of the other staff wouldn’t look after him. I got lumped with him, not lumped in, like I said sure, I didn’t really argue it, but there were a lot of people who said ‘I’m not going to look after him’._

I asked Andrew if he treated this patient any differently. He replied:

_Do you do anything differently? Ultimately I think I didn’t, but still in the back of your mind you’re thinking about what he’s done and you think well, we have to treat this guy, but it’s a little bit unfair when there’s other people who are sick as well. I do know some people do go in with that mentality, ‘Why do they deserve this?’ ‘Why are my taxpayer dollars paying for this?’_

Andrew’s dialogue was peppered with contradictions. Andrew espoused a belief that prisoner-patients were entitled to equal health care, but placed limitations on that entitlement. Andrew frankly admitted that he tried not to get involved with prisoner-patients and that his care for them was not always delivered with empathy. He frankly questioned whether it was fair to offer non-discriminatory care to prisoner-patients, when there were many other sick people were arguably more deserving of care.

Embedded in Andrew's prejudices were significant ideas that shaped his experiences with prisoner-patients. These ideas were developed into the following horizons: _I value fairness and equity; experience helps; and it is an internal struggle._

From his dialogue, it is clear that Andrew _valued fairness and equity_ and strove not to judge prisoner-patients. He actively employed behaviours to assist him in this quest. Andrew identified factors that impeded his ability to be non-judgemental, such as situations where registered nurses knew the patient's crime. Thus, he deliberately did not seek this information out, thereby attempting to limit the influence this might have on his caring behaviours. However, he was not always successful and at times, his natural curiosity prevailed. In his attempts to be fair and equitable, Andrew admitted that he adjusted his caring practices and became
task orientated, losing some of the warmth and emotional elements of his care. Andrew believed that all prisoners were entitled to high quality health care and that this principle was important, hence he endeavoured to deliver this.

Andrew considered that experience helped him to develop and grow in his ability to care for prisoner-patients. He asserted that he developed ways to establish the genuine needs of the prisoner-patient regarding analgesia. Andrew approached prisoner-patients from a position of confidence, yet acknowledged that the potential was there for the experience to be confronting and frightening.

Finally, Andrew found the experience of caring for prisoner-patients an internal struggle that placed an emotional pressure on him. He reassured himself and actively tried not to dwell on the issues he was exposed to, even though these things were resident in the back of his mind and affected him profoundly. Andrew focused his attention on the routine tasks of nursing care and kept busy as he tried to push it out of his mind, to avoid thinking about some of the more stressful, challenging aspects of prisoner-patient care.
Beth

At the time of her interviews, Beth was an experienced nurse with a young family. Having spent her entire nursing career at this hospital, Beth had a significant history of caring for prisoner-patients and was able to recall stories from when she was a very young nurse, memories that still had a significant impact on her. A noteworthy event in Beth’s nursing experience occurred when a close friend’s father, who was incarcerated for child sexual abuse, was a prisoner-patient in the hospital. This challenged Beth on many levels and coloured her view not only of this particular patient, but of prisoner-patients in general. Beth openly disclosed that she did not like prisoner-patients. Beth was aware of what she wanted to do to be a ‘good nurse’, but she also found ‘trying to do the right thing’ was a struggle when taking care of prisoner-patients. In her interview, Beth remarked that being involved in the research as a participant caused her to consider several things that she had not thought of before and, as a result, her practice changed. Through analysis of her dialogue,

Beth’s prejudices were identified as:
- You just want to get rid of them;
- Knowing makes a difference, I don’t like them;
- I don’t feel frightened any more;
- Guards are not there to be nice to them; and
- You’ve got to care.

You just want to get rid of them

Beth spoke of caring for prisoner-patients as being a struggle and hard work. Her focus was on getting the prisoner-patient out of recovery and back to their room as expediently as possible. She limited her interactions with prisoner-patients, which challenged Beth’s concept of a good nurse. She struggled with wanting to provide care and yet was aware that on some level she limited her care.
Findings:

She expressed these thoughts:

>You pull away, you are probably very distant with them, and you don’t ask them about their lives. Whereas with a lot of our general patients you do… I never ask them [prisoner-patients] if they’re married, if they had a job before prison or whatever. Sometimes I just can’t think about it too much. I just look after them because sometimes they’re hard slog to get analgised, or to get comfortable in bed. It’s busy most days and you just want to get rid of them. It is draining with them; the physical care of them is draining enough.

Like Andrew, Beth tried not to think about her care of prisoner-patients too much. Not only did Beth profess that she just wanted to get rid of prisoner-patients, she frankly admitted that her ‘care’ was not ‘caring’. Indeed, she expressed that she lacked the will to care. She continued:

>With patients you don’t really like, you don’t go that extra bit for them, or that sort of emotional bit for them either… it’s all we really do, that post-op physical care. I think I look after them really well from a physical point of view. I don’t know how much emotional care we give them; I suppose I don’t give a lot… I still think I hold back on them, I’m not very demonstrative with them or just soothing, comforting with them. I don’t think I am, it all becomes a bit guarded – like you just want to keep them moving… and not have time to think about it… I don’t have to [care] or else I probably couldn’t do it, couldn’t work.

For Beth, thoughts of distance, both physically and emotionally, were highlighted when she spoke of wanting to get rid of prisoner-patients quickly. She continued these thoughts when she said:

>The thing is, we make a distinction between them and anyone else that we care for. They’re definitely, without a doubt, stigmatised and that’s hard, you find it permeates the whole theatre. You pull away from them, you put up a wall or barrier with them and yeah, you never touch… it’s funny, I probably never touch a prisoner-patient… definitely, and it’s all unconscious you know. You don’t want to; it goes against everything about me being a good nurse and what a good nurse does… I think we should be nice and look after them. I think we should nurture them... It goes against my nature, I’m usually not mean to people.

Beth considered prisoner-patients were stigmatised and her experience was permeated with explicit examples of withholding care. These feelings were compounded for Beth if she was aware of the prisoner-patient’s crime, which will be discussed in the next prejudice.
Knowing makes a difference, I don’t like them

Although Beth preferred to ‘turn off’ and not think about the patient’s crime as a strategy to help her remain indifferent, this was not always possible. At times when she knew what the prisoner-patient did, she developed negative feelings towards them. Beth spoke of the impact that not liking a prisoner-patient had on her ability to interact with them. It was hard for Beth to separate ‘knowing the crime’ and ‘liking the patient’. As she explained:

*I reckon it is easier if you don’t know what they’ve done, you just turn off. You often get young staff, who are quite interested and I just say STOP, <participant emphasis>. It definitely makes a difference… and I think definitely it is easier when you don’t know.*

She continued to describe how knowledge of the crime made caring for the prisoner-patient more difficult, when she said:

*You are not supposed to know what prisoners have done wrong and I did. And it was really difficult… I didn’t like him very much… it does make a difference of course, because this man had a history of sexual molestation of girls, so it really did make a difference for me. I didn’t like him and I didn’t like what he did… it definitely makes a difference.*

Overtly, Beth’s dialogue revealed that she structured her nursing care based on assumptions that she made about the patient. Not only knowing the crime, but other elements contributed to her not liking prisoner-patients. She shared that prisoner-patients can’t be trusted, are dangerous, challenging and manipulative. She said:

*You often think that they’re dangerous and you always think that they’re going to con you… You know, you can tell someone who has IV drug use problems, definitely. You get duped by them and you know it’s going to happen… you know, predominantly they’re men, their gender; they can be a bit intimidating at times. They can be aggressive, they can be hard… they can be violent sometimes… some really bad types. You are always, are a bit suspicious that they are out to con [hit] you or something.*

The experience of caring for prisoner-patients was compounded by a number of factors; she often didn’t like prisoner-patients, especially when she knew what they had done. Over time Beth learned to overcome fear, which will be explored in the next prejudice.
I don’t feel frightened any more

Early in her experience, Beth felt frightened while caring for prisoner-patients. However, like Andrew, she described how knowing the routine, how the place worked and becoming experienced gave her an advantage. Beth recollected a story that occurred nearly 20 years ago that made a lasting impression on her when, as a junior nurse, she felt frightened. Beth remembered:

*What he did to himself was shocking and he was a danger to society... he was really, really tricky to look after. He wasn’t a very nice man either; he was actually one that I was really frightened to look after in recovery.*

Beth reported similar responses from other less experienced staff:

*A lot of new nurses are quite frightened when they come to recovery, or when they have a prisoner to care for. People don't know how to deal with them, even things like the prison ward, that freaks some people out. I don't feel frightened any more... they [nurses] are a lot younger, these kids and they haven't seen as much as we have. That might be fear, I reckon, but I don't have that fear any more. It's changed over the years, it's not so scary but that's probably experience.*

She further reflected:

*I'm quite comfortable with all that stuff that a lot of people aren't comfortable with. I'm not that intimidated by it because I know how the place runs. How did I learn to look after prisoners? I just watched people; you probably get very influenced by others.*

Like Andrew, Beth said that over time she became experienced and she intimated that her experience had hardened her. She said:

*I think sometimes around prisoners they think you are pretty, not dumb, but naive. I don't think I am anymore; I am pretty 'wake up' to them now. I’ve woken up to it all.*

Guards are not there to be nice to them

Beth discussed how she struggled to care for prisoner-patients in the way she cared for her other patients. Part of the struggle for Beth was the influence of the guards and the way their presence altered her relationship with the prisoner-patient. She discussed a conflict between her nursing role and the prison guards’ agenda.
As Beth explained:

*I think we should be nice, look after them, nurture them and all that stuff, and care for them. Whereas when you see a guard treating them hard, you know, I find that difficult. I find guards, they will tell you what the prisoner has done. I've had a few cases where they've said they're molesters or not so much murderers it's more... rape, women's crime, rape against women, stuff like that they like to tell you about.*

During the discussion I had an idea and asked Beth whether she thought the guards told us this because they thought we were being too nice to a prisoner whom they believed was undeserving. She said:

*Definitely, I think guards think we treat them too nicely. Some guards are troublemakers, you can tell they are troublesome, we are here to nurse, to look after patients and care for them, whereas they're not. That is the difference; you know they're not there to be nice to them.*

In the midst of this dissonant dialogue, Beth revealed her ideal of nursing practice. That is, she voiced that nurses are there to care for patients, yet she also asserted that with prisoner-patients she withheld care.

Further, Beth discussed a blurring of the roles of custody and care and indicated confusion about boundaries:

*I've had to say to the guards 'look can you not get involved in their personal care?' You just have to say 'look we're right here, thank you very much'. That's really hard, because you don't know where their job starts and ends, and where my job starts and ends, you have to discipline them. I suppose when do we stop being a nurse and start being a guard?*

There was a clear contradiction in Beth’s dialogue about struggling to care for prisoner-patients and her belief about what nursing prisoner-patients entailed. Whereas, she spoke of an imperative for nurses to be ‘nice’, in the context of caring for prisoner-patients Beth struggled. For much of the discussion, Beth was unaware of this conflict yet, as her dialogue revealed, she developed new insights as our conversation continued. This is seen in the next prejudice, ‘You've got to care’.
You've got to care

Beth openly verbalised her dislike of prisoner-patients. She discussed that caring for prisoner-patients was hard yet, despite this, part of the nursing ideal for Beth was the imperative to care. The idea that caring for prisoner-patients was an expectation was voiced by most participants and as Beth expressed it:

“We are not in the position where we say ‘I don’t want to look after this patient’. We can’t do that; we have to really unless… someone in the department has to look after them. You can ask someone else to look after them, but other than that, they’ve got to be cared for, and you can’t walk out on them, you’ve got to care.”

In expressing this, Beth revealed an epiphany when she experienced a change in her attitude and feelings towards caring for prisoner-patients. She discussed this when she said:

“What we discussed made me think about how I care and my caring for them. It was interesting and you really made me think about how I treat them, treat the [prisoner] patients.

She later reflected:

“When I thought about what we had said, you know, how I look after them, I decided that I just wasn’t going to treat them as prisoners any more; they were just patients, that’s actually how I do it now. After our talk I really did think about how I treat them and it’s interesting, it’s not a prejudice, but that’s a good word to use and I sort of thought I probably don’t treat them as a normal… it’s always in my head, they are a prisoner, they’ve done something, but now I don’t. I just forget it. I’m thinking that they are just patients, they are just my regular patients now, and that was really after reflecting on what I’d said and sort of talking about it with other people out there generating a bit of discussion, what do you think about looking after prisoners? It was interesting.

For Beth, the experience of caring for prisoner-patients changed dramatically as a result of her personal reflection on her nursing care in part triggered by the interview process where she heard herself say things out loud that surprised and challenged her. This change was identified during the second interview which was an unexpected benefit of the returning to the participants a second time.

Taking into consideration all that Beth shared regarding her experience of caring for prisoner-patients her experience was exemplified through the following
horizons: nursing prisoner-patients is onerous; care is rudimentary; yet she believed there is an imperative to care. The experience of caring for prisoner-patients was onerous for Beth, and she suggested it was a heavy burden that weighed her down. Her struggle was accentuated because Beth instinctively disliked many prisoner-patients; this feeling was heightened if she had knowledge of their crime. Part of her dislike for prisoner-patients was that Beth was constantly on guard; she verbalised that prisoner-patients were going to manipulate her, make her look foolish or hurt her in some way. This she took as a given. These feelings meant she struggled to interact with prisoner-patients in a meaningful way and this made Beth’s experience an onerous one that was a burden for her. Beth struggled to provide the type of nursing care that she felt was worthy of herself as a nurse and worthy of the prisoners-patients. Experience reduced the feeling that the care of prisoner-patients was hard; Beth considered that it had become easier with time and that she was able to share some of what she had learnt with younger staff. However, the overwhelming experience for Beth was that the care of prisoner-patients was a challenge.

Beth frankly acknowledged the rudimentary care she gave to prisoner-patients in that it lacked the extras, like chatting by the bedside, informal communication, touch and general comfort. Beth spoke of her care as being distant – she pulled away and held back, illustrating that her care was emotionally restricted. There was a gap here between what she did, that is, provide ‘non-caring’ care to prisoner-patients, and what she said was the ‘right thing to do’, which was to be nice and treat prisoner-patients the same as other patients. For Beth there was also an imperative to care irrespective of the challenges faced, hence Beth challenged the prison guards’ criticism of the way nurses cared for prisoner-patients. After periods of reflection, Beth verbalised that she wanted to change and to embody a caring ethos when working with prisoner-patients.
Ella

Ella was a 25-year-old nurse with three years of nursing experience, mostly in the operating suite, at the time she was interviewed. Conversation with Ella focused on her struggle to find a balance between asserting and protecting herself while working with prisoner-patients and her personal discovery of what it meant to be a good nurse. Permeating Ella’s discussion were feelings of judgement. Her care could often be described as a reaction in response to the prisoner-patients’ behaviour, looks and general demeanor. Through analysis of Ella’s dialogue, four prejudices emerged which were:

- I judge them;
- I detach and guard up;
- A challenging experience; and
- Sometimes you glimpse the real person.

I judge them

Ella verbalised a strong desire to be true to herself; to be open about her emotions and the impact they had on her. She was aware that she was conflicted – as she said, part of her judged prisoner-patients, while at the same time she felt sorry for them. Ella’s frank expressions of her judgement of prisoner-patients were different from that articulated by other participants. For most participants their goal was to work towards being as non-judgemental as possible. Ella considered being non-judgemental to be against human nature, that she couldn’t help being judgemental and she needed to acknowledge that in her care. Ella said:

Whilst I don’t mean to, a lot of the time, I do detach, because it’s hard. It’s frustrating, because part of me judges them and part of me feels sorry for them. You are just being judgemental. I think it’s human nature. If you know the way their brain works to make them do a really bad thing, how can you not judge them? How can you not judge their value system? Yeah, I judge them.

For Ella there were characteristics and qualities about patients that determined the type of caring in which she would engage. This was evident when she compared two prisoner-patients she looked after on the same day.
Findings:

She began with:

*He did not get my empathy at all. I think there were a couple of components; I was not sympathetic about him and his weight. We could not get him to stay still, that made me frustrated and then the fact that he was a prisoner and we were just letting him literally do whatever he wanted to do.*

Concerning another patient, she said:

*The other guy we had in the other corner that day, [was] perfectly polite, so I was empathetic for him, didn't have a problem having a laugh and a joke with him. I definitely had negative feelings after the first guys' situation compared to this other chap; he was so pleasant and not even pleasant just like [he met] a basic human standard.*

She continued to compare the two patients:

*I had that dude the other day and I was not empathetic to him at all. I was so not willing to stretch beyond my means for him. The other guy I had was so polite and appropriate and I was happy, I found myself extending a hand to his shoulder when I don’t normally do that. I didn’t have a problem resting my hand on his shoulder because I wasn’t threatened by him.*

Ella’s response was clearly different when presented with two prisoner-patients in different circumstances. Her discussion about judging prisoner-patients continued when she suggested caring was easy if she saw herself as better than they were. She explained:

*Sometimes if they are really scummy looking, they are talking foul or they are just not a clean cut girl/guy, you tend to feel a bit more empowered. I think it can be a little easier when they are less respectable because you look at them and go ‘well, yeah, I am better than you.’ I know that’s a really blunt way of looking at it, but sometimes – why should I take this [expletive]? I am not in a position where I should have to be taking any [expletive].*

A commonly expressed sentiment in Ella’s discussion was that human nature caused her to respond in the ways that she did. She explained:

*I do think we get caught up in the judgement thing a lot without realising. Human nature, how can you not judge? I think it is something we do subconsciously. It is pretty unfair when you think about it, that you generalise straight away.*

Ella continued to discuss judging prisoner-patients; she referred to an experience where she found out the prisoner-patient’s crime after the fact:
Findings:

She said:

Had I known that, I would have treated him differently, it is just a given, no matter what you are like. I don’t care who [expletive] that ‘I would have been fine’, I don’t care. Human nature says you wouldn’t have been able to treat him like you didn’t know. I would have treated him differently and I’m not afraid to admit that.

Ella also said:

It will affect the way I look after them; I know that that is just human nature. How can you know, for example, that someone has raped children and still be tender, loving, and nice to them, you can’t. You might pretend to be, but it is not genuine.

Like many of the other participants, for Ella not knowing the prisoner-patient’s crime made caring easier. She explained:

I think if you don’t know, you are in a much better position to provide care... if you can keep completely separate from their conviction, to just why they are here and what you are doing for them, it gets a lot easier to maintain ideals.

Ella’s experience was one of being outspokenly judgemental, an element of her care which she attributed to human nature. Through this expression, Ella implied that her behaviour was innate, not directly under her control, which suggested that she assumed no direct responsibility for her actions or feelings. Another aspect of her care that Ella considered she had very little control over, were her experiences of care and caring, as is explored in the following prejudice, ‘I detach and guard up’.

I detach and guard up

Ella verbalised that maintaining her distance with prisoner-patients and being on guard was an essential and desirable trait. She expressed this as a self-protective mechanism which was a necessary part of her nursing role. This prejudice was particularly noticeable when Ella discussed her lack of touching and physical contact with prisoner-patients. Ella spoke of the threat prisoner-patients presented, again attributing her response to human nature. In her words:

I think it is human nature when you know there is a potential threat, to put your guard up. Naturally, I don’t think that’s a bad thing... I think if you became complacent about it, you’d find yourself in a bit of trouble... I think as a nurse in our situation there is no alternative.
Ella also discussed the importance of being on guard, being defensive and how that feeling influenced her care. She said:

*I think if you are intelligent enough you can pre-empt a nasty situation. It doesn’t do any harm to be on your toes, or to look more actively for signs of aggression, they are a bit more of a threat than your everyday patient because they are in jail, so that is clearly an indication. There are definitely behaviours that elicit a change in my management of prisoners [compared to] the ordinary patients. They do test the boundaries... I would be more stern with them.*

This being on guard often resulted in Ella placing distance between herself and prisoner-patients. She explained:

*Whilst I don’t mean to, a lot of the time, some of the time, I do detach a little... not because I thought he was dirty or gross or anything like that, but I just didn’t have to be involved, I could kind of distance myself.*

She expanded on this distance by saying:

*I’m a big toucher, I believe that caring ... is the emotional component, and for me that’s touching… but I am not always that touchy with prisoners... not as sympathetic.*

Ella poignantly provided some insight into why she was generally defensive. She said:

*It really breaks my heart, particularly when they are so young, so for me, I detach a little bit, not because I think they are dirty or unsavoury, but because I feel like if I was in touch with my emotional self with those patients, like that all the time, I would just be broken.*

Our conversation turned to the principles on which Ella based her care. She explained that she wanted to engage in unconditional caring, which was her nursing ideal. But, in saying this, she also had a keen awareness of her inability to reach this ideal. Ella reported that she tried to treat prisoner-patients the same as other patients, and it was the trying that was important.
Findings:

She said:

*I think I try to treat prisoners the same as other patients, I’m conscious of that when it’s happening. I think they are human beings just as much as the next person… I’d like to think I don’t fake it. I do really think there are some patients for which I do have more caring than others. I don’t mean I withhold it from others. I mean with some… it is just natural you just have an overflow for some... with others it’s not fake, just monitored or limited, maybe.*

With prisoner-patients, Ella maintained that she often didn’t have that natural inclination. She gave an example of when she was aware that her care was less than ideal:

*I kind of felt a bit bad that I was such a cow on the inside, I don’t think I was nasty to him, but I knew I was a cow on the inside to him… I wasn’t rough with him, but I definitely wasn’t as soft and gentle with him.*

Almost as an exception to the rule, Ella spoke of an example when she demonstrated caring to a prisoner-patient. It stood out to her as something out of the ordinary. She said:

*I found myself kind of empathising and being a bit more compassionate and I did find myself touching him and I remember afterwards thinking, “Oh wow! Why did I do that?”*

And when talking about caring, she stated:

*I think it would take a pretty amazing person to give it [unconditional caring] in its entirety. I am well aware of my omissions. I don’t think I could give it in its entirety whether I wanted to or not. I don’t think you have a choice at that juncture, if you clam up, you clam up.*

Ella said her experience of caring for prisoner-patients to be almost something out of her control. Instinctively, she judged them and kept a distance or detached from them as an innate response. All this contributed to make the experience a challenging one.
A challenging experience

Ella implied that she embraced the experience of caring for prisoner-patients and met it as a challenge. Ella started the discussion by saying:

_They don't seem to be any different than other patients, just different needs… I often put my hand up, because I feel it's going to be a challenge, it's always a challenge, they are all different, it's just going to be a different set of circumstances and a different challenge. I have often found it more challenging than any other patient, because there is that stigma attached to them straight away._

Ella seemed unaware that there were apparent contradictions in her dialogue about prisoner-patients. For example, she offered that prisoner-patients were not different to other patients, yet described them as more of a challenge than standard patients, as is seen below, when she revealed her views of the challenges that caring for a prisoner-patient imposed: She said:

_It is more of a challenge than the stock standard patient, because most of them have a history of drug use. Their appearance can be a bit threatening, all their tattoos, piercing, poor hygiene… these guys aren't subtle. If they get fiery, that kind of thing, then definitely I get a little bit frightened._

Ella's discussion was rich with descriptions of distance and judgement, then occasionally she verbalised feelings of compassion and intimacy. These contrasts really highlight the challenges that Ella faced:

_It’s challenging but often rewarding, I think they just need a little bit more hard work than the everyday patient. They just need that little bit more, whether it comes to analgesia or just general compassion or attention. I think sometimes they just do need that little bit of work. I think often if you do put in that little bit of effort you will get the good reward, whether that be that they tell you that they are pain free or the least amount of pain they have been in for so long. Or that you got personal with them, which is probably something no one has done for a long time – it’s kind of nice._

Ella spoke of giving in to prisoner-patients’ demands when she talked about analgesia delivery. She said:

_I don’t know, sometimes it’s easier just to oblige them at times, than it is to argue the point. Because you are not going to get anywhere in general and they can turn and become a bit nasty. When the patient comes into recovery the mood changes, it doesn’t get extremely welcoming. It kind of closes up a little bit._
Findings:

Despite suggesting that prisoner-patients were no different, Ella was challenged when caring for prisoner-patients but said someone had to care for them.

**Sometimes you glimpse the real person**

Although Ella acknowledged challenges associated with caring for prisoner-patients, she maintained an ideal of what care of prisoner-patients should be like and that ‘Someone’s got to do it’. She said:

> I think it’s important to treat them as you would any other patient…
> I think they are a human being just as much as the next person.
> They might not be the most savoury of characters, but you’ve still got to care.

She added:

> I think they’re a human being just as much as the next person. If you have managed them to the best of your ability… you may get a glimpse of the real person… it’s almost like that’s more rewarding than getting a thank you from your average patient, who just takes you for granted. I don’t know; it’s profound at times.

Ella continued:

> I do believe they are entitled. They are prisoners, great, but they are patients too, and they deserve care, someone’s got to do it. If they are sick someone’s got to look after them… I don’t know if it’s important to be nice to them, but I think it is important to treat them the same as you would any other patient.

This imperative to care had limitations; Ella considered she had to care, but she didn’t necessarily have to be nice when she did.

I thought about Ella’s prejudices deeply and concluded that her horizons were: **not caring is a natural response**: prisoner-patients do not meet my standard; and **prisoners are real people after all**. Ella believed that caring or not caring was a natural response, something that came from within. She suggested at times that she had more caring feelings for some patients than for others; this was not something that she intended but it happened on a subconscious level. Much of Ella’s judgement she attributed to a natural response, human nature that was beyond her control. In this way, she absolved herself from the responsibility for restricting her care and justified her behaviour.
Another horizon for Ella was the acknowledgement that prisoner-patients did not meet her standard for how people should behave. Prisoners just did just not measure up to this basic human standard. As a consequence she judged them, kept her distance, guarded up and didn’t touch them. She described prisoner-patients as a threat, aggressive and that their appearance was rough. By placing prisoner-patients at an arm's length, the evocation was that Ella felt empowered and 'better than' prisoner-patients, as she met this arbitrary standard.

Finally, Ella acknowledged that prisoners are real people after all. Ella indicated that underneath all the crime, the way prisoner-patients looked and acted, they were real people who had the ability to touch her in a deep and significant way. Fundamentally, despite all her judgements and bravado, Ella was able to feel empathy for prisoner-patients. She believed in the ideal that all prisoners are entitled to health care and that nurses have an obligation to care. But there was still a risk to letting her guard down because, as she said if she allowed them to touch her she would just be broken. She considered the goal of unconditional caring was hard to reach, only obtainable by someone amazing.
Ruby

Ruby, at the time of her interview, was a nurse with 18 months’ experience. She came to the operating theatre as a graduate nurse and remained there the following year. Over the period of data collection, Ruby gained experience and confidence. After deeply considering what Ruby shared at interview, her prejudices were identified as:

- My response to prisoner-patients depends on the guards;
- (Sometimes) they are like normal patients;
- I’m glad I’ve never known;
- I am more comfortable with it now; and
- They deserve the best care we can give.

My response to prisoner-patients depends on the guards

Ruby expressed quite strongly that her experience with prisoner-patients was directly influenced by the behaviour of the prison guards. She took cues from the manner in which the guards related to prisoner-patients. The influence of the guards on the perceptions of the nurse was mentioned by other participants, but Ruby was significantly prejudiced by this experience. In her words:

*I think it depends on the guard whether I feel uncomfortable, if they’re really relaxed, I’m not as worried. It doesn’t concern me so much, but if they’re really watching over them like hawks and maybe the prisoner has a handcuff on them then I think they [the prisoner-patient] must be a really bad person.*

If the guards were in close proximity to Ruby and the patient, Ruby became self-conscious. The guards’ presence had an impact on how Ruby perceived prisoner-patients and also on how she acted. She said:

*Probably again it comes down to how comfortable I am with it, if the guards are a bit more relaxed and sitting away I feel like I can talk to the prisoner a bit more and make that sort of small talk, but if the guards are right there on top of the patient, I don’t know, maybe because I’m feeling a little bit more on edge about it, I don’t talk to them [prisoner-patients] so much, or interact with them so much.*

Ruby went on to explain how the guards made working with some prisoner-patients either straightforward or problematic.
She said:

*He was just really difficult to work with and the guards were really on edge as well – it just makes a huge difference. Whereas if they’re relaxed and calmer, it sort of makes you calmer. But if they wake up all aggressive, it puts you on edge.*

Ruby acknowledged that judging a prisoner-patient based on the guards’ behaviour might not be fair. As she explained:

*I’m not sure, but it’s probably not right because it doesn’t reflect the prisoner so much as it might just be the guards. Do you know what I mean? Whether they’ve got a power trip and they just want… they’re right on top of the patient… it probably doesn’t reflect the patient.*

As was expressed by many of the other participants and consistent with my own experiences, Ruby felt analgesia delivery to prisoner-patients was difficult. The guards had an impact on her response to the patient, but what also concerned Ruby was her perception of what the guards felt she was doing:

*[Intravenous] drug users in general tend to say ‘oh 10 out of 10 pain’ because they know that they’ll get strong drugs. But I’ve been a bit disappointed a couple of times when I have had a patient and they’ve said ‘I do have a lot of pain’ and they probably do, but I’ll hear the guards snicker as you walk off to get the medication. I can hear them go ‘oh of course he’s got 10 out of 10 pain’. They say that to each other, they have a really different view on it.*

When I asked Ruby if she felt that the guards believed she was being manipulated, her response indicated the dynamic between her and the guards was less than optimal: She said:

*Yeah, the way they snicker, like when you are doing a pain assessment, which you have to do for all patients anyway, so I don’t see why you don’t do it for someone who’s used drugs in the past, they’re still going to get pain. So yeah, I think they do probably think we are just a bit naive.*

The guards are always present with prisoner-patients, and Ruby found this placed additional pressure on her experience and had a negative influence on both her care and on her judgements of prisoner-patients.
(Sometimes) they are like normal patients

In addition to Ruby’s care being influenced by the guards, she expressed that the prisoner-patient themselves also influenced the type of care she gave both positively and negatively. Generally, she found prisoner-patients to be like ‘normal’ patients. She said it several times:

They have all been really good in recovery. I’ve only looked after a few but they’ve all been quite nice. You probably wouldn’t know they’re a prisoner apart from the fact that the guards are standing there or they are handcuffed to the bed.

Most of the prisoners have been pretty nice and pretty easygoing in recovery. They are a lot more easygoing sometimes than other patients.

They are actually pretty good to look after. They are really appreciative of the care and the time I’m putting into them.

Ruby generally found prisoner-patients to be like ‘normal’ patients, but at times she had an experience where caring for the prisoner-patient was a challenge. In a similar way to Ella, Ruby’s dialogue highlighted a situation when she had two very different experiences looking after two different prisoner-patients. She began:

It depends on the patient and depends on how relaxed the guards are. The last patient I had was a young girl and she didn’t seem like she should be in prison, I know you shouldn’t put labels on people, but she just didn’t. She was so nice and gentle, guards just sat back, weren’t concerned or anything, so it was really easy to look after her.

Ruby then went on to compare this experience with another prisoner-patient. She said:

Whereas I guess I can think of a situation where I had a male prisoner and he was acting, he woke up from his general anaesthetic quite aggressively… he was just really difficult to work with. He was being quite, not really physically aggressive or anything, but really, really nasty.

She continued:

He was scary compared to having the girl who was all calm and nice. You wouldn’t even have pictured her as a prisoner apart from the guards.

Later in our conversation, I asked Ruby if she engaged with prisoner-patients in the same way that she engaged with other patients. Ruby referred back to this example.
Findings:

She said:

*I guess it depends on them. Like with the girl that I looked after, I engaged with her really well, just like she was a normal patient cause she was really good to work with. But, for example, if they wake up aggressively, like this guy that I had who was refusing monitoring, then it's a bit hard.*

In this expression, Ruby revealed that the care she gave to prisoner-patients was responsive to how they looked and acted. She expressed she found it easy to care for patients whom she considered to be ‘normal’, yet on the other hand at times a prisoner-patient acted in a way that challenged Ruby’s ability or desire to care. One way that helped Ruby treat prisoner-patients as ‘normal’ was not knowing what crime they had committed, which will be explored in the next prejudice.

*I'm glad I've never known*

Unlike the other participants, Ruby had never looked after a prisoner-patient for whom she knew the crime that led to their incarceration or remand. In this respect, her story was unusual. She was not able to compare knowing with not knowing but she did discuss, on a hypothetical level, how knowing might cause her behaviour to change. She said:

*I've never ever known what the patient has done and I'd probably prefer not to. I would be concerned that it might affect the way I care for them. If I know they've hurt little children or raped innocent women or beat up the elderly, it would just make me not want to help them as much… it might make me feel funny.*

Ruby explained the ethical dilemma she would face if she knew the patient’s crime:

*I don't think I would want <participant emphasis> it to make a difference, but I think that it probably could … depending on what they've done. I think if I knew that they had hurt little children, you know, murdered people or horrible things like that, I think I would have in the back of my mind, you know, that they are not very nice. But everyone deserves a right to equal health care, so I think I prefer not to know. I don't want to be told. I think there was a time when we did have one prisoner and someone recognised the name and someone was going to look it up to see what they'd done and I walked away, I said 'I don't want to know'*.  

Like several of the other participants, Ruby identified that not knowing what the prisoner-patient did was a means of self-protection. Not knowing helped her meet her caring goals.
She said:

*I also don’t want to know so I can provide better nursing care, for myself, but I probably do kid myself, probably to make myself feel better. I prefer not knowing and I’d like to keep it that way, it would probably scare me and put me on edge if I knew, so I prefer not to. There was this one time I wondered. I thought ‘If he can be this aggressive, this nasty with his words, I wonder what he’d done?’*

She added:

*It’s probably to keep myself sane, I don’t want to know ‘cause some people have done horrible things and some people haven’t really done much and they’re in prison… I mean you can’t trust them completely, even if they haven’t done much, they’ve done something.*

Ruby relayed that she was worried her care might change if she knew the prisoner-patient’s crime. She also discussed that she kept a distance from prisoner-patients, both emotionally and physically, even without knowing prisoner-patients crime, because the thought of what the crime was might impact on her care of prisoner-patients. Ruby tried to treat the prisoner-patient like anyone else. She suggested:

*I guess I probably just step back a bit and not think about it, not getting tied in emotionally, not worrying about the fact that they’re a prisoner. Just thinking: ‘Yip they’re a patient, just like everyone else’ and just treating them as such, as much as you can.*

Ruby again mentioned trying to ignore the fact the patient was a prisoner. She said:

*I wouldn’t like to know for my peace of mind. I would rather just think that they are a patient and that’s all they are and try and sort of cut out the fact that they are a prisoner.*

I wondered if Ruby altered her care regimen when caring for prisoner-patients and so I asked her if she was worried that there were parts of nursing care she might not be giving prisoner-patients. She replied:

*Probably just giving them more of myself I guess. I give them the basic nursing care that they need in recovery… whatever they need. I probably wouldn’t interact with them as much, because I would have it in the back of my mind. I do interact quite a lot with all my patients. If you haven’t got that rapport you don’t feel like you’re going to give as good nursing care.*
She went on to say:

_I feel like I have given them the care, but I probably wouldn't feel satisfied, go away and say 'I really helped, feel like I'd really helped them' as much. I wouldn't feel like I'd helped as much compared to the other patients I'd had that day._

Ruby had a desire to help prisoner-patients. She preferred to care for prisoner-patients without knowing what they had done so that she could remain in a sense naïve; however, even without knowing a prisoner-patient's crime, Ruby's care was restricted and distant at times.

**I am more comfortable with it now**

Most participants expressed that gaining experience over their time of caring for prisoner-patients was an enabling factor. Ruby revealed that over time she thought less about what the prisoner-patient had done in terms of their crime and was able to focus more on them as a patient. She said:

_Yeah it is a bit different, but I feel I am just more comfortable with it now. Even though I haven’t been doing it for long._

Ruby reflected back over the last year. She said:

_I think that I’m getting better at it. When I first started working here and the thought of even recovering a prisoner 'oh my God that’s really scary’ but now, I don’t know, they are actually pretty good to look after. I’m maybe not as emotionally involved, but I just don’t have that process in my mind like 'what have they done, oh they’re a prisoner.’ It doesn’t really faze me as much and I think that’s maybe from looking after more prisoners._

She spoke of feeling increasingly comfortable about caring for prisoner-patients:

_I think that’s just from having looked after a few more because I think that when I’d had the first interview with you, I hadn’t really looked after that many myself in recovery, I’ve looked after a lot more and a variation, different patients like female, male, the way they interact differently with us as well, it becomes a bit easier… it becomes a little bit easier. Some things come as second nature._

Experience enabled Ruby to feel more comfortable with prisoner-patients as many of her concerns did not eventuated and she found the experience became easier. Ruby fundamentally believed prisoner-patients deserved quality health care.
They deserve the best care we can give

Ruby maintained that everyone was entitled to health care, irrespective of what they did in the past. She maintained that it was important to embrace a position of ethical neutrality. Ruby stated:

*I think it is because technically they should be treated, they have a right to health treatment and treatment in the hospital just as any other patient does. So whatever they’ve done in the past shouldn’t affect your care. They’re serving time, so they have been punished for whatever they’ve done so it shouldn’t... I don’t think it’s right to feel that way.*

Ruby didn’t always deliver the same care that she gave everyone else, but she was convinced that it was an important goal. She mentioned situations where it was difficult. She said:

*I don’t think it would be ethically right to look after them if your feelings are going to change; your feelings towards them are going to affect the nursing care. I think that would be better off for someone else to look after them. Someone that can distance their feelings in that way, but I just don’t think I could.*

But then she reiterated the point:

*But then they deserve equal health care, everyone, they deserve the same health care as everyone else does.*

I asked Ruby if she thought it was possible for prisoner-patients to receive the same nursing care as everyone else. She replied:

*Well probably not, I guess, I don’t know, I guess probably not. I guess that they just deserve the health care that you can give them, the situation relevant to them.*

In a similar vein to other participants the ideal of health care for all was important to Ruby, but she gave with some limitations; in this instance, prisoner-patients deserved the best health care the nurse was able to deliver, not unconditional health care.

Through considered analysis and reflection on Ruby’s’ prejudices, the horizons that I identified for Ruby were: **care is influenced by others, ignorance is better and I do my best.** Ruby’s **care was influenced by others.** Guards, the prisoner-patient and other nurses all influenced Ruby’s experiences and directed her care. The guards’ behaviour suggested to Ruby whether the prisoner-patient was good,
worthy or not. Not only did the guards give her a guide to the prisoner-patient’s worth, but she considered that they questioned her care at times, which caused Ruby to doubt her ability. The prisoner-patient also had an impact on Ruby’s ability to care. Ruby found the prisoner-patients were either nice or nasty, their looks and personality flavoured the view she held of them and the type of care she enacted. Generally if Ruby found prisoner-patients were ‘normal’ and ‘nice’ and she found care was easy to enact. But occasionally Ruby came across a prisoner-patient that she deemed not to be ‘normal’ and she found it a challenge to care for them.

The second horizon for Ruby was that ignorance is better. Ruby did not want to know what crime the prisoner-patient had committed, nor did she want to focus on the fact that they were a prisoner because she knew she might not treat them well if she did. Ruby adopted tactics that enabled her to distance herself from the status of patient as prisoner. She maintained a strong preference not to know the prisoner-patient’s crime, as she was concerned how this influenced her care. She considered this ignorance gave her peace of mind, and enabled her to deliver nursing care; she was glad not to know.

Ruby maintained I do my best. Over time she could see that her care for and interactions with prisoner-patients had developed and grown. She found that, with experience, she improved and developed her ability to meet some of the challenges of caring for prisoner-patients. For example, Ruby worked hard at doing the best job she could, despite the prison guards belittling her decisions to give prisoner-patients analgesia. Not knowing the prisoner-patient’s crime was another way that Ruby sought to do her job well, because she had a strong sense that, if she knew the crime the prisoner-patient committed, it would impact on her ability to do her best. Finally, Ruby embraced the idea that prisoners deserved the best care she could give them, care that was free of judgement and equal to the care other patients expected. This belief that prisoners deserved the best care, was not necessarily met by her practice, as she qualified the statement to suggest that the best care really meant the best care a nurse was able to enact in a given situation. Yet Ruby maintained an ideal that she worked towards.
Sarah

When Sarah was interviewed, she was in her late twenties. She had varied nursing experience, including working in the mental health area, which she expressed gave her an inside edge when caring for prisoner-patients. She left the perioperative area of practice shortly after her first interview, and consequently was one of the two participants not available for a second interview or any periods of observation. In her dialogue, Sarah focused strongly on her rights, her own protection and wanting to be in control. Although Sarah voiced that she was non-judgemental, her dialogue did not support this assertion. Analysis of Sarah’s dialogue revealed the following prejudices:

- I have a right to know;
- We should be given a choice; and
- I think it is intimidating so I keep an arm’s length.

I have a right to know

Sarah was very definite that she always wanted to know the crime a prisoner-patient had been charged with, or convicted of, resulting in their incarceration. She went out of her way to seek this information and expressed that it was her right to know. However, as these details are considered confidential, she did not often succeed. The lack of knowledge of prisoner-patients crime, Sarah viewed as a hindrance in her ability to care for prisoner-patients. This was in sharp contrast to the expressions of other participants who, although at times expressed curiosity or found out the prisoner’s crime incidentally, rarely sought out this information. Interestingly, Sarah maintained that knowing the patient was a prisoner and knowing their crime did not affect her interaction with them and in fact she claimed this was necessary to enable her to understand ‘the whole picture’. She relayed:

*I’m always curious about what they’ve done. Some people say that you shouldn’t know, because it can interfere with your care for the patient. But I don’t discriminate, no matter what. Sometimes for my safety it’s been something I’ve wanted to know about, especially when they’ve been looking mean and tough and I’m thinking ‘I could get a broken jaw or something out of it’.*
She also shared:

I think generally that it would be a good idea for me to know about it. Because if someone is particularly violent, then I believe I have a right to know, based on what they’re capable of… with psych patients when you’re on the ward, you have access to their files to look at their medical history so you know how to treat them. Certainly I think it should be similar in the prison population, because it can mean the difference between your safety and not. Some people believe that they prefer not to know, but for me personally it’s not about that, it’s more about understanding the whole picture of the patient.

Because I found aspects of her comments curious, I specifically followed up this dialogue with a question about whether Sarah thought her practice changed in any way if she knew details of what the prisoner-patient had done. She asserted:

No, as a practitioner it doesn’t change the way that I feel about someone because of what they’ve done or their background. If they’re reasonable to me in terms of behaving themselves and being polite, then they will get exactly the same back from me. I will treat a patient with contempt if they swear at me and are rude, they’re nasty and non-compliant. Then I’m going to be a little bit more prickly than I would be with someone who’s just going to be open to receiving care. But that is irrespective of where they’ve come from, so no, it doesn’t affect my care.

Sarah asserted that knowledge of the crime did not affect her care, in a subtle distinction she suggested what affected her care was the prisoner-patients behaviour. Despite feeling that knowledge of the crime was important, Sarah only twice found out what a prisoner-patient had done; she relayed the following:

I’ve only ever found out twice, once was a more well known offender and his face had been in the papers and stuff, so I had recognised him and then one other time I was told because I asked. That was when I first started here and this guy was a paedophile, sure there was some certain disgust, because I think that is one of the most disgusting offences anyone could perform, especially with children. I just think it’s horrendous but, it wouldn’t change the way I dealt with him you know necessarily.

While Sarah maintained that her care did not change with prisoner-patients, when she found out a patient was a paedophile she said it was horrendous and disgusting. For Sarah, being non-judgemental influenced her ability to perform tasks but did not appear to include what she was feeling, as she was often critical of prisoner-patients in her dialogue. Contradictions in dialogue are not unique to
Findings:

Sarah, but they are particularly evident in some of her comments. When I asked her to explain what non-judgemental meant, she went on to say:

> It’s not up to me to pass judgement on where he’s come from and what he’s done and whether or not he’s got some sort of sick mental illness, which a lot of people with that background have. I don’t really understand the psychology here as to why people behave in a certain way but I can certainly say he wouldn’t be someone I’d vote for, but that doesn’t mean I’ll deny him any analgesia because I think he’s horrible, but definitely I would not feel compassion necessarily towards him.

For Sarah, the right to know what crime a prisoner-patient had committed helped her feel in control and in a sense she equated knowledge with power. Another way Sarah liked to be in control was to have a choice as to whether she would care for a prisoner-patient, which is explored in the next prejudice.

**We should be given a choice**

In addition to Sarah believing that she had the right to know the crime a prisoner-patient had committed, she also considered that as a nurse she should be able to decide which patients she would look after. She regarded prisoner-patients as dangerous, and wanted a choice; she said:

> I think that you should be given the choice. It shouldn’t be just an expectation that that’s part of the role that you should play within the recovery room, because these are dangerous people. That’s why they are in jail and I think you should have the choice and you’re not given the choice.

She further elaborated:

> It’s expected by the institution that you are punctual with dealing with those sorts of offenders. I don’t think we’re given a choice here. Instead this person’s coming out, before you know it and the only reason you know they’re a prisoner and what they’ve done is because they’ve got six cops standing around.

Sarah asserted that the patient’s status of prisoner made no difference to her care of them and yet she felt it was important to be given the choice to look after them.

**I think it is intimidating, so I keep an arm’s length**

Clearly, Sarah expressed that caring for prisoner-patients was intimidating and this caused her to keep them at arm’s length.
She vocalised concerns for her safety and explained:

> I think that it is intimidating. It’s potentially dangerous for us just to be around the patient. If there were to be someone who dressed up like a cleaner and got their way into recovery and popped a guy off, then you could be someone who was a victim in the situation as well... I think that you need to have a true understanding of what has gone on and the way in which it operates... I think it’s something that you don’t truly understand when you first start working here, it’s just an expectation that you will take this patient on.

Sarah continued:

> I think that some of them are intimidating. I’ve dealt with one [prisoner-patient] in particular who had about five federal cops who were heavily armed and were on all the exits. Initially he looked really mean – and I found that intimidating, I was a bit nervous that day.

Later in our discussion, Sarah said that being intimidated restricted care delivery:

> Well I think for some people it does affect the way they treat people and they do feel intimidated, and they’re not able to deliver the level of care you know that they would do to an 88 year old grandmother.

Sarah asserted that she kept her distance from prisoner-patients. The distance was physical, as she was intimidated and concerned that she might get hurt, and it also impacted on her care where she suggested that she kept it ‘professional’ and didn’t do the extra bits in terms of emotional support. She said:

> I just keep a distance a little bit. I care for them and I attend to them as per I would anyone else. But I definitely keep arm’s length, for the simple fact that they are angry people with maybe not much of a future.

As Sarah continued her dialogue, she expanded on her notion of what caring for prisoner-patients entailed. She said:

> More guarded I suppose... I wouldn’t pat them on the head or something like that. I’m definitely cautious physically of them, because they’re generally big guys. Most of the guys in recovery look really quite mean and they’re powerful and large. And I don’t tend to feel that I need to display that kind of attention towards them. But then keeping it professional doesn’t mean that you need to go that extra length in terms of support.
Sarah made assumptions about prisoner-patients; based on how she thought they might act, she limited the type of care she gave by standing back both physically and emotionally.

After deep consideration of Sarah’s prejudices, the horizons elicited from her experiences were: **it is important to be in control** and **care is earned not deserved.** It was important to Sarah to **be in control.** At times in her care of prisoner-patients, Sarah expressed feeling intimidated and nervous and taking control was necessary for her to be able to address this and interact with prisoner-patients. Sarah believed it was her right to know the crime the prisoner-patient had committed so she had a full sense of the situation she was in. In her interactions with prisoner-patients, Sarah intimated that with knowledge she also gained power within her relationship with prisoner-patients. Another example of Sarah trying to maintain control was her wanting to have the choice whether or not to look after a prisoner-patient in the recovery room.

Sarah’s care of prisoner-patients is encapsulated under the horizon **care is earned not deserved.** Sarah suggested she did not discriminate and yet her interactions with prisoner-patients were dictated by their behaviour and looks. Sarah described her response to prisoner-patients as directly proportional to their behaviour; she would respond to someone she considered rude with rudeness and contempt, for example. The prisoner-patient was not assured care at the outset; there was little in the way of grace or compassion from Sarah and prisoner-patients had to earn care by their good behaviour. There was no discussion about caring about prisoner-patients from Sarah; she used words like ‘practitioner’ and ‘professional’ to imply an emotional distance and she suggested that, because she was professional, she didn’t need to go the extra length in terms of support. Sarah focused her care on the tasks at hand; ‘she would attend to them’ rather than engage in a relationship with a prisoner-patient.
Prudence

Prudence worked in the perioperative environment for six years at the time of her interview. She had postgraduate qualifications in the area, which involved an additional year's university study, and was a clinical nurse specialist, a professional title given to senior nurses that denotes significant clinical experience. Prudence emphasised in our discussion that her nursing care of prisoners was no different from the way she cared for other patients. She believed that it didn't cause her any undue concern and didn't frighten her unless she knew what crime they had committed. However, during discussion with Prudence, other aspects of the experience became apparent.

Prudence’s five prejudices were:

- Initially I believed the stereotype;
- It doesn’t faze me unless I know what they’ve done;
- Emotion shouldn’t be expected;
- They are still patients; and
- I make assumptions and get nervous.

Initially I believed the stereotype

Throughout our conversation, Prudence spoke of how her care and experiences of caring for prisoner-patients changed over time. Initially her experiences were coloured by stereotypes, but gradually she became more comfortable with giving nursing care to prisoner-patients and treating them as individuals. She spoke of being afraid early on when she said:

Yeah, probably just going along with, believing the stereotype that all these prisoners are there because they have done the worst thing in the world ever. You’re scared – but now after looking after loads of them and meeting all different types, in prison for all different things, I’m not intimidated really at all… unless they are really a nasty person.
This stereotypical image influenced Prudence’s early experiences; she gave an example:

> When I first started I was frightened of all prisoners. I was really quite horrified because I’d never looked after a patient who’d been handcuffed to a bed, but I’m used to that now. I was quite nervous, I did expect he was going to be a big huge guy who stole children and killed women. I think that being shackled to the bed, handcuffed to the bed, I was probably a bit nervous. But that was a few years ago and I am just kind of used to it now.

Prudence expressed her underlying fear with prisoner-patients was that she did not know what they might do next. This fear was similar to Andrew, who gave voice to the potential of what might go wrong. The fear of things that could potentially go wrong is closely linked to her stereotypical view of prisoner-patients, that they were bad and would do something wrong. She said:

> I’m wondering if they’re going to do something and that’s the ones that come out covered in tatts with the guards, who immediately shackle [handcuff] and stuff like that and you think oh [expletive], are they going to do something? It’s never happened. None of them has ever done anything… but they might. Yeah, but again that’s the stereotype, this guy’s got tatts everywhere, oh yeah, he must want to punch me when he wakes up.

Later she commented:

> They are obviously in jail because they have done something wrong. It could be stealing a loaf of bread or it could be chopping some women’s head off, you don’t know what they’ve done. You’re getting a patient who’s a prisoner, you don’t know what they’ve done, you haven’t seen them yet, they could be anything… so you probably are a little bit nervous… but it’s reassuring to have the guards there in case they fly off the handle. But none of them ever have while I’ve been there.

Prudence realised there was a difference between being afraid and the reality of her experience. She said:

> I mean, to be perfectly honest; most of the prisoners I’ve looked after have been fine. I’ve never had a problem with them, they’ve always been pretty pleasant, I look after other patients that were probably worse, more aggressive and creepy.

> Well, yeah, maybe a little bit more wary but on the whole I don’t think you probably need to be that wary of them. They’re generally all right.
Prudence relayed a story of a nurse who was chatty with prisoner-patients, which shaped her own experience: This story demonstrated that she was able to see a funny side of caring for prisoner-patients.

She goes: ‘he was the nicest guy, the nicest guy’ and so I felt ‘well it’s probably not that bad you can probably chat with them. I mean I’m sure he’s probably not quite so nice when he held up the bank at bloody gunpoint’… I was like ‘are you serious?’ ‘She replied, ‘yeah he’s got like 10 years to go apparently but he knows where the money is’ [then] she goes ‘are you going to tell me where it is?’ he goes ‘No’. I thought that was funny.

Concern about what the patient might do was compounded for Prudence if she knew the prisoner-patient’s crime; if the crime was something that did not offend Prudence too much, like robbing a bank, then it interfered less with her care than if it was something she struggled with morally.

**It doesn’t faze me unless I know what they’ve done**

In a similar manner to Ella, Prudence revealed that her caring attitudes changed if she knew the crime the prisoner-patient had committed. Early in our conversation, when I asked Prudence how she felt about giving care to prisoner-patients, she suggested:

Oh I don’t mind. Like it doesn’t faze me at all, unless I know what they’ve done, then sometimes… but otherwise prisoners in recovery, you don’t know what they’ve done. There isn’t any issue, you just treat them the same as any other patient.

When asked about caring for prisoner-patients, Prudence made a distinction between caring for them and having a caring attitude:

**Certainly not in the activity, but your attitude might [change] if you knew what they’d done. So this guy yesterday, I read in his notes he’d been in jail for kidnapping, so my care, the activities <participant emphasis> and that didn’t change, but in my head I was thinking my attitude <participant emphasis> probably did change a bit. Not that he would know, but certainly I didn’t care for him as much as I would any other patient.**
As the discussion continued, I asked Prudence why she thought there was a difference between her activities and attitude:

> Just because I think he has done a vile thing and just not wanting to care. I wish I didn’t have that attitude but I do, I’m just being honest, I feel bad, but there is nothing I can do about it, it is what it is. Not that my activity has changed at all because he is still being nursed, but my empathy is definitely less.

And later:

> I wouldn’t connect with them on an emotional level, I would still care for them but I might not say ‘Would you like another pillow?’ Also I wouldn’t talk to them a lot… and I wouldn’t be interested in what they had to say to me either.

There was a clear delineation for Prudence between caring for and caring about prisoner-patients. If she was perturbed because she knew the prisoner-patient’s crime, like Prudence, Beth restricted her care to prisoner-patients. Like Ella, Prudence identified that restricting one’s care was something that could not be controlled.

**Emotion shouldn’t be expected**

Caring was a natural response for Prudence. For some patients although Prudence did not feel naturally caring or empathetic, she considered it important to give care. She began by talking about prisoner-patients, when she said:

> I mean some of them have a little bit of attitude and are a little bit rough around the edges, so if they’re not very nice people, you’re not going to treat them like most people who are nice... I find it [caring] comes naturally, some of them might be creepy and a bit weird, but again there are people in the general public who are like that as well, so you know, it just kind of comes naturally.

Prudence considered that caring for prisoner-patients was an integral part of her job, but maintained that emotionally caring for some patients could be justifiably restricted:

> I think everyone deserves this, regardless of what they have done; we still have to care for them. But to have the emotion behind it, I don’t think it should be expected. But we are professional – I think we should still be expected to care for them, the cooks at the prison, they still cook for them.
For Prudence, looking after prisoner-patients or any patient was her job and with that came certain expectations. She asserted that caring was a natural response that could not be forced, but caring was not automatically a part of her role.

They are still patients

Prudence considered the caring response as being natural. There were several examples throughout Prudence’s dialogue where she stood up for prisoner-patients; this also was a natural inclination. She said:

*It is easy to nurse someone you actually care about, that you want to advocate for and protect. If you force it, you are not being true to yourself.*

Examples of her human concern for patients included her disappointment in the way guards treated a high-profile prisoner, where she found herself protecting him despite knowing what he had done. In her words:

*When I looked after that guy, those guards were being awful to him and you know he’s done a terrible thing, like you couldn’t imagine doing that yourself, but he is still a patient and they were being awful. They were being really inappropriate and I was getting really cross.*

Prudence found herself asserting the patient’s rights to the guards, when they interfered. She gave an example:

*Like when you are giving them pain relief and you say ‘how is your pain?’ and then the guards say ‘yeah if you are sore you should say something now so we can go back upstairs’ and you look at them and go ‘excuse me’.*

In addition to challenging interactions guards have with prisoner-patients, Prudence found the guards’ presence led her to make assumptions about prisoner-patients and they made her nervous, a prejudice which will be explained next.
I make assumptions and get nervous

The presence and actions of the prison guards influenced Prudence’s reactions to prisoner-patients and the assumptions that she made. For example, she said:

*The fact that the guards are there makes it a little bit different, and they have to handcuff them to the bed now as soon as they’re awake. If the prisoner comes out and they’re all around him and shackling them down then you think ‘oh well this person’s done something wrong.’ Whereas often they’re sitting at the back reading a book they don’t even know. So I guess you do make assumptions, they’re beside him, he must have done something bad. He’s a high-profile prisoner.*

Prudence also observed that having the guards watching everything she did made her nervous:

*Sometimes they start talking as well and interfering with your care of the patient, which is really quite frustrating and plus being that they’re there watching the patient but they’re also watching what you do and I don’t… someone’s watching me, it could be anyone, I probably get a bit nervous.*

The influence of the guards’ presence on Prudence’s care was similar to that described by most other participants; the guards were like a barometer of the prisoner-patients’ worth.

After dwelling with Prudence’s dialogue and deep consideration of these prejudices, I identified the following horizons: **I wear a mask** and **prisoners are generally all right.** Prudence **wore a mask** when caring for prisoner-patients. She said several times that her nursing care of prisoner-patients was no different from that of other patients. Yet in her dialogue she frequently discussed care that was different, devoid of empathy and emotions behind her actions. She went through the motions of giving care and acted appropriately, but was aware that she did not feel the same level of emotional connection that she did for other patients. She said the patient would not notice any difference, but she was acutely aware that she was different on the inside; what she thought and felt was altered and she was hiding behind a mask. Prudence also gave care without the extras or niceties, doing the essentials only. This lack of connection and not wanting to care was not something Prudence felt she could control; she felt it occurred on a natural level and came from within her. Although she was resigned to it, she did, however, feel bad about it and said it was not ideal.
Prudence found prisoners are generally all right. Early on in her experiences, she imagined the worst with her interactions with prisoner-patients that they would be violent and want to hurt her. But, over time, Prudence found prisoner-patients were generally polite and pleasant. She was able to interact and laugh with them as with any other patient. The stereotype that prisoners were manipulative, drug seeking, bad people was not the reality of her experience. Occasionally Prudence cared for a prisoner-patient who she knew committed terrible crime and although nervous and apprehensive at meeting them, they were often quiet and withdrawn and did not cause her too many concerns.
Julie

Julie studied perioperative nursing at another hospital and although she was a very experienced perioperative nurse, she had no previous exposure to prisoner-patients in the 12 months prior to being employed by the study hospital. Julia’s experience of caring for prisoner-patients was expressed as interplay between two positions. She voiced an element of curiosity and fear about the crime the person had committed, which led to her keep some distance between herself and prisoner-patients. These thoughts were juxtaposed with her expressions of prisoner-patients’ as human beings who seemed as nice and polite as any other patient.

Julie’s prejudices were identified as:

- Knowing shuts you down emotionally;
- I play it cool;
- I feel self-conscious;
- I want it to be about me and the patient; and
- Nursing from a checklist.

Knowing shuts you down emotionally

Julie, like most of the participants, preferred not to know the nature of the crime the prisoner-patient was accused, but that did not stop her from wondering and being curious. Like myself, Julie rationalised to help her engage with prisoner-patients – for example, she pictured a crime that did not have a significant human cost and did not affect people. She explained:

>You know they’ve done something. They are not going to be in jail because they’ve helped an old lady across the street. They’ve done something, and it’s going to be something that’s not good for society. I know what I’m like, I would wonder… There was this case where I found out and I’m so glad that I didn’t find out with the other ones, I really don’t want to know. You try to rationalise in your mind and you try to imagine… you try not to think that it is too awful. I’m sure it’s just this or that. I’m sure they’re in for armed robbery or something that I want it to be.
Findings:

She also said:

> Usually I don’t want to know what they’re in for because the one time I did know what someone had done, it was a particularly horrendous child murder. I knew about the case and I felt myself shut down emotionally. I was like ‘oh my God.’ I didn’t want to have a reaction but it was just that crime. The anaesthetist was there and they had quite a strong reaction as well, there was this moment of OK, right… and it wasn’t even about the patient, it was about us.

In addition to professing that she sometimes shut down emotionally when looking after prisoner-patients, Julie also disclosed that she used a mantra when working with prisoner-patients.

**I play it cool**

There was, for many of the participants, an underlying fear that something might go wrong, similar to the thoughts expressed by Andrew ‘just because a dog has a lead doesn’t mean he won’t bite’. Julie expressed this by describing conversations she had with herself, reassuring herself that she was fine. There was a judgemental element to her fear, where she made assumptions about prisoner-patients based on the way they looked. She revealed:

> You get that connotation because often they are covered in tattoos, rough around the edges and the guys can be quite big and beefy, oh there’s only little me and I know there’s these two guards but it’s just me. I try not to draw attention to the fact that they are from prison. In my head, your internal voice or whatever you want to call it, is just going, ‘play it cool, play it cool’ it’s OK, you are just reassuring yourself that you’re fine, you know, telling myself ‘you are safe, it’s fine’.

This fear that something might go wrong was further highlighted when Julie commented:

> It’s in the back of your mind the whole time; I keep an eye on where things like paperclips and stuff are at, just in case they got their hands on a paperclip. I’ve seen too many movies where they get out of their cuffs with a paperclip.

Externally Julie carried out various nursing care tasks but, as is seen from her dialogue, internally there was a battle going on.
Findings:

I feel self-conscious

The presence of the guards made Julie feel very self-conscious. She also felt self-conscious in front of the prisoner-patient, particularly when the interaction was about analgesia and drug delivery. She said:

There is a moment of thinking I don’t want to do anything that might antagonise these people [the guards]. They’ve got weapons, they look scary, and if I drop something will they shoot me?

The guards added an extra dynamic to the nurse–patient relationship; Julie explained:

I think I feel like the guards are watching me. I’ve got a bit of an audience and that’s probably the main thing. Sometimes you want to communicate with your patient and you’ve got four eyes boring through your head.

Julie felt self-conscious and awkward when discussing certain things with prisoner-patients; she continued:

I think I just feel a little bit self-conscious about certain things like talking about drugs and stuff with them… particularly if they are asking for specific drugs and you don’t even know what that drug is. If they need to be re-cannulated and they say ‘you won’t get a vein over there’. Stuff like that you just feel a little bit, it’s almost like a self-conscious thing.

I want it to be about me and the patient

Julie’s desire was to bring the nurse–prisoner-patient relationship back to its essence without complications that could arise. She focused on providing care and tried to ignore some of the other issues such as the prisoner status of the patient, the guards and any judgemental thoughts she might have. Julie relayed a particular experience she had with a prisoner-patient. She said:

OK well I’m not going to ask her what she’s in for… ‘don’t ask, don’t let her know you want to know what she’s in for’… and all this sort of thing. I was like, let’s just keep it about her pain. I got it down to ‘What are the safe things that I can deal with this person? OK let’s just focus on keeping her comfortable and getting her up to the ward’… I want it to be about me and the patient rather than having the guards involved and things. I want to try I guess to scale it down, so that it is a nurse–patient thing as opposed to thinking that they are a prisoner.
Julie often spoke of the importance of the nurse–patient relationship. She explained:

*I’m looking at her and she’s a human being, I saw a human being come out with an airway in. You’re not wanting to think about the logistics of everything. This is a patient; you’re going to look after this patient, to do your job.*

The development of a nurse–prisoner-patient relationship was easier if the prisoner-patient spent extended periods of time with Julie, and then Julie could see the barriers began to break down. She said:

*It’s interesting because if it’s someone who you know, they’ve had a little bit of pain, and so for whatever reason you’ve kept them for a slightly extended period, and you actually got talking to them about stuff. You actually have started to develop that whole interaction with them, actually chatted with them quite a bit and they may have even told you what they’ve been put in for, you know and they’re missing their family. Sometimes I do, I go home, OK they are in for that… and then it’s kind of the conflict you are thinking about between this is what they are in for and they seem like a really nice person.*

She added:

*It just leaves you wondering and you wonder why they did that, and if they haven’t told you, then you kind of go ‘he seems like a nice guy, what could he possibly have done?’ [or] ‘she seems like a nice person’… and I find it’s interesting. This is my thing, the women prisoners I wonder more about than the men… she looks like my mum, you know.*

It was almost startling for Julie when she realised there was a person in the bed, not just a prisoner; however, she acknowledged that aspects of her care were automated and not patient-centred.

**Nursing from a checklist**

Julie said that her nursing care was automated, in response to feeling fearful and self-consciousness. She suggested she tried to be the same with prisoner-patients as she was with other patients, but she became more activity-focused in her care with prisoner-patients. She said:

*It almost becomes automated. What do I have to do, it’s like you have this checklist of things in your head. I need this patient to be pain free or as comfortable as possible. They need to have no nausea. What are the requirements for this patient and just work through that.*
Findings:

Julie limited the interactions she had with prisoner-patients. She added:

*Other than that I think that I try to be the same. I probably don’t engage with them as much like by talking about personal things; you might talk to patients about family, you know, share stories and stuff with them, I probably don’t.*

This dialogue was reminiscent of that of Andrew’s who kept to a routine, and to Ella’s story, who was detached and guarded when caring for prisoner patients.

The horizons that I elicited from deep consideration of Julie’s prejudices were: **it’s an internal struggle**: and **there is a person behind the label**. These horizons will now be explored further. It is evident that Julie’s dialogue revealed the experience of caring for prisoner-patients to be **an internal struggle**. Events and emotions caused her to ‘shut down’ and pull back emotionally. She dealt with fear and apprehension by reiterating mantras to herself, ‘it will be fine’, ‘play it cool’, for example. She attempted to compartmentalise information and put it in the back of her mind in order for her to interact with prisoner-patients and she played games with herself, pretending what the prisoner-patient might have done. Julie also engaged in a style of nursing care that was stripped back to activities, that was automated and a little soulless at times, despite her efforts to try to be the same with prisoner-patients.

Julie acknowledged that **there is a person behind the label** of prisoner. When Julie had the opportunity to interact with prisoner-patients for an extended period of time, Julie glimpsed the person behind the label of prisoner and was able to engage with a patient; she found the prisoner-patients were generally likable and nice. This interaction between distance and forming a relationship with the prisoner-patient encapsulated the experience for Julie. Her focus was on protecting a relationship; while struggling to enact nursing care. Julie focused on the prisoner-patient and tried to eliminate elements that distorted this dynamic such as knowledge of the prisoner-patient’s crime.
Belinda

Belinda had previously worked full-time at the hospital and at the time of her interview she was working part-time. She was in her mid-forties and experience was evident in the ideas she shared during her interview. Belinda fervently believed that our society has an obligation to provide health care for prisoner-patients. She did not feel intimidated or physically threatened by prisoners at any time, which was different from the experience of most of the other participants, but she found the experience a challenge, simply because the patients were labelled ‘prisoners’, in particular if their crime was known.

After reflecting on Belinda’s dialogue, the following five prejudices were identified:

- Knowing changes you;
- You are wary;
- You’ve got to own your feelings;
- Everyone is entitled, it is a dignified society; and
- Workplace as sacred.

Knowing changes you

Belinda maintained that knowing the crime a prisoner had committed changed the way she felt and her ability to nurse them, in both positive and negative ways. She said:

Knowing changes you, knowing changes how you are, and I don’t know if that is a protective mechanism or what, but it’s just classic labelling theory. They become the crime and you can tell that.

On one occasion, Belinda inadvertently read in the patient history about what the patient had done. I asked her to explain why it changed her; she responded:

I think that is multifaceted. I think it was circumstance [of the crime] and I think it was how I felt at a personal level. I think professionally I behaved as I would with anyone else, but those other two factors [the circumstances of the crime and her response] do influence. The history that comes with the prison was with the medical history and I didn’t realise, it was just sort of open and he was a young guy – so just disbelief I guess, because you read it in the newspapers and you think my God…
Findings:

The experience stayed with her as later in the second interview, she spoke of the same patient:

*I don’t think we should know about the crime, because of all the prisoners that I’ve looked after I remember that boy who was 28 whose file I read.*

She continued:

*This little voice in your head says ‘in all honesty, I wonder what they did’. You look at them and it’s almost a little bit of curiosity. That they are a prisoner creates a bit of a prejudice in so much as you’re wary. You know more about that patient than you do about other patients, you know that in some way they have become a prisoner. Prisoners in our society are separated, we don’t know a whole lot about them and generally we assume that they have done something bad, broken the law and they are taken out of society.*

Television is one way nurses found out who a prisoner-patient was and what they did. There was an element of celebrity attached to some prisoner-patients who were recognisable faces from media reports. Belinda explained further:

*There is a bit of excitement attached to it as well. There is a bit of wow, normally we don’t encounter people like this in everyday life and so it’s almost like, even though we are safe, in a safe environment, having something to do with people that are, in inverted commas, ‘dangerous’ so it’s a bit… maybe we are prejudiced by so many things, by television shows and you know everyone is not a psychopathic killer or something like that.*

Belinda encountered a high profile prisoner who shot and killed a man, on the previous day. I asked her how knowing what he did impacted on her care. Belinda was quite reflective in her response and drew on the experience as a positive one:

*It was so high-profile… that was in itself a bizarre experience. I guess what he did outraged people, so that was really unusual. I think I’ve learnt from it. It was an experience that was positive. I think the knowing part of it, that they are a prisoner, creates a bit of a prejudice. It’s more of a conscious effort to be as caring and professional, you’ve actually got to make an effort. It asks a bit more of you and that reflects what I said about the knowing part.*

Belinda looked on situations that she found challenging, for example, knowing the crime a prisoner-patient committed, as a chance to grow and learn about herself; as she said, the care of prisoner-patients asked a bit more of her and at times required her to be wary.
You are wary

Belinda talked about being conscious of the effort it took to care for prisoner-patients. She struggled to sum this up and used the term ‘wary’, which can mean cautious, careful and vigilant. The caring was different; in her words:

_ Wary I think is the word. I think you have to make a definite effort to overcome that wariness, I think maybe in all of us we are wary and I keep saying wary, but I don’t know any other word to describe it._

Belinda suggested the type of caring involved was different. It was forced, required more effort and was less innate. She said:

_ Clinically they are the same, I think that they are just like every other patient, but in a way you can’t delude yourself and say that they are like every other patient… I think you have to make more of an effort, it’s a different caring, it comes from a different place, with more of an effort… It is unnatural because you have to force it, it is not natural because you are guarded… self-protection, self-preservation, it’s protective behaviour._

Belinda expressed nurses were wary and because of this they interacted less with prisoner-patients; she explained:

_ I think there’s more interaction with nurses with non-prisoner-patients, not on a really huge level, I don’t think they are boycotted, but you would tend to avoid them. I don’t think that you have the same rapport with the [prisoner] patient, you don’t have that same intimacy with the [prisoner] patient that you do with other patients._

Belinda chose to provide basic care for prisoner-patients. However, in exercising this choice, she also asserted that it was important to own your own feelings, a prejudice which will now be explored further.

You’ve got to own your feelings

Belinda suggested it was important to acknowledge her feelings, especially if she had difficulty caring for a prisoner-patient. My own initial understanding of the experience was that nurses did not recognise their feelings of the experience as being difficult, but Belinda demonstrated this was not always the case. It was however, not something that was discussed by many of the participants as, within the recovery room, there was an expectation that all nurses would be willing to care
for any patient, prisoners included. Belinda looked after a known paedophile; she discussed her feelings and difficulties with caring for him. She acknowledged:

I think what’s necessary is to recognise that in yourself, to try to get someone who doesn’t have that problem. Perhaps a younger person who doesn’t have children. To recognise that to say ‘OK if I do look after this patient it will compromise their care in some way, in some aspect’ and just to own it. And if you can’t, if you do have to look after them, you’ve got to own it and say, ‘OK I’ve got to do my best here’, but own the fact that you do feel like that. You should not have to deny it, or feel bad about that.

Belinda spoke previously about her choice to deliver care that was very basic when she had a problem with a patient. She wanted nurses to take responsibility for how they felt. She said:

We are human beings, so just own it, and recognise it, and try and either not to look after that patient or get assistance. There are a whole lot of things you could do, set up some strategies.

She gave an example of a time when people needed to step aside and let others care for a patient because their feelings interfered with their ability to care. She said:

I think the fact that he had touched people’s lives here, one of the surgeons walks through recovery, he said ‘oh he shot my best mate’, and so many people had an opinion about it. He was treated differently by everybody, how the doctors came up and spoke to him was terse, there were no nice words. He used the bare minimum of words he had to use and you could just feel the resentment… no-one wanted to look after him.

Belinda felt a ‘one-size-fits-all’ approach to the nurse–prisoner dynamic was not appropriate, and that nurses had a responsibility to acknowledge when they had a problem caring for a prisoner-patient. If needed, they should get someone else to care for the patient. Yet she also believed that everyone, including prisoner-patients, were entitled to care because we live in a dignified society, which will now be discussed.

Everyone is entitled, it is a dignified society

Throughout our conversation, Belinda acknowledged things that were different or more challenging when caring for prisoner-patients, but the underlying premise in her dialogue, was that we needed to strive to deliver health care to all, even in a basic form.
She said:

_I think we live in a dignified society… you have to decide what level you’re going to operate mentally and physically at. Everyone is entitled to health care, and I think we live in a civilised society and we have to treat each other with dignity so… regardless of who the person is, you still have to maintain your standards and your care. I was pleased, I look back and I was pleased with how I treated him, interacted with him and cared for him. I stand by my belief that we do live in a dignified society and everybody is entitled to health care, it is good to be able to do that._

Participants frequently spoke of feelings of fear and intimidation when caring for prisoner-patients but Belinda was able to be empathetic and acknowledge the vulnerability of the prison patients. She said:

_They are really disempowered. It’s the most disempowered they’re ever going to be. They’re totally at the mercy of the system and usually they are quite gracious and grateful. You know, a mother loved that child._

These feelings of empathy and entitlement were just one layer of Belinda’s experience. As will be seen in the next prejudice, she struggled with other aspects of caring for prisoner-patients.

**Workplace as sacred**

The workplace as a sacred or special place was a belief that was voiced by a number of participants during their interview; there was congruence between the thoughts Belinda expressed and those of Beth, Ella and Tracey. They asserted their work environment was familiar and comfortable – a place they had good memories about.

Belinda felt violated by the presence of prisoner-patients; it was akin to inviting them into her home:

_It was their workspace and this man had performed such a violent crime, a known violent crime, they felt their workplace was somehow violated and their sanctuary had been invaded a little bit by this known source of evil. People were saying ‘oh it was horrible, I felt really, really creepy that he was… yeah, that he was in their workspace. It just made me realise just how sacred the workplace was, it’s a sanctuary, you do feel safe there._
And again, using the same example, she said:

_He did an outrageous thing in a busy morning and it was so high-profile about the man that he shot— he was a father of three, just a white knight, so it touched on all those things that are sacred to us. The workplace is sacred, we come here and we feel safe and his presence was almost contaminating it… you come to work and feel safe, I come to work and feel safe._

There was an ownership, a responsibility, for the environment in which they worked. It was more than a place in which they spent time; they were invested in what went on there. Embedded in Belinda’s dialogue were significant prejudices that after some thought I developed into three horizons, which were: **we have choices** and **prisoners require different care** and **caring for prisoners violates you**.

Belinda believed **we have choices**. Much of Belinda’s discussion revolved around the choices that she made as a nurse when providing care for prisoner-patients. Belinda’s dialogue revealed two sides of the same coin. On one side, she expressed that although she was wary she made an effort to care and worked hard at it. She acknowledged that we live in a civil society where care is an entitlement, even for prisoner-patients. As Belinda described it, we have to decide at what level we will operate.

On the other side of the coin Belinda also described that **prisoners require different care**. As she said, nursing prisoners changes you; it required more effort, was unnatural or forced and asked more of you. When discussing prisoner-patients, Belinda described care in its basic form, becoming rudimentary, where the act of merely maintaining standards required effort. Belinda spoke of being wary of or distant towards prisoner-patients. In a sense, this wariness needed to be overcome so the nurse and patient could engage. This required a conscious and determined effort that was diametrically opposed to a natural inclination. Belinda considered **caring for prisoners violates you**. The presence of a prisoner-patient changed her workplace from somewhere safe to a place where she was uncomfortable; they encroached on her personal space in a manner that Belinda resented. Their status of prisoner changed the way she felt about them as patients and impeded her ability to deliver the care she valued.
Rachael

Rachael worked in the perioperative area for more than nine years at the time of her interview. Rachael strove to treat prisoner-patients with respect and dignity, but acknowledged that there was a difference between the way she cared for them and other patients. Rachael’s prejudices as identified through her dialogue were:

- Initially I was very hesitant;
- We should look after all patients the same, but maybe we don’t;
- Analgesia requirements are greater; and
- I have compassion.

Initially I was very hesitant

There was a hesitancy that Rachael mentioned, in particular early on in her career, but also permeating her entire experience of caring for prisoner-patients. However, experience and time contributed to Rachael feeling less apprehensive and increasingly comfortable. Rachael described feeling more comfortable when she said:

Things have certainly changed since I first started in the theatre complex nine years ago. Initially I was very, very hesitant. I think it was for me, when I first arrived, the thought of looking after a prisoner scared me a little. I found I was hesitant even to mention what my name was… certainly things have changed since then, I feel a lot more comfortable looking after prisoners, and I don’t worry as long as I don’t give them too much personal information.

I knew Rachael had the reputation of being a bit of a ‘chatterbox’ in the unit. So I asked her whether she interacted with prisoners in her usual chatty manner. She replied:

No, I still sit next to them and I will chat along to them, perhaps I’m too open and give a bit too much information to [general] patients about myself, but I’m a little more hesitant, much more hesitant with prisoners.

She spoke of being generally apprehensive and described the situation of caring for prisoner-patients as being foreign to her.
She said:

*When I first started here it was foreign, they’re a foreign kind of individual. The fear of the unknown, the whole system of guards, with revolvers… some high security patients that are shackled here and shackled there… I am a bit apprehensive, I mean, it shouldn’t change the way we feel about them but the thought of these high risk prisoners, sometimes in my brain I used to think, ‘oh what have they done’?*

However, over time, Rachael expressed that there were some benefits of experience and said:

*I think experience gives you more insight and it allows you to become less judgemental I think with the treating of prisoners… having been a nurse for numerous years now and working in the theatre environment, I feel you become more immune to taking things personally.*

While Rachael spoke of being apprehensive and hesitant, she also acknowledged internal feelings that influenced her ability to externally demonstrate her care.

**We should look after all patients the same, but maybe we don’t**

Equality in external manifestations of care or the activities of care was important to Rachael. She strove to be non-judgemental and look after all patients in the same manner and to some extent she achieved this. Although she acknowledged throughout our conversation that there were differences. She said:

*The fact of the matter is we should look after all patients the same. They deserve to be treated with dignity, with compassion. I think that for me personally I’m now treating them exactly the same as any other patient. I try to live my life Gods way… still if they ask, I don’t answer personal questions. I had to get over the idea that I could be assaulted by them, but I know it won’t happen, it doesn’t happen and there’s always the guards there.*

Later Rachael spoke of her observations of prisoner-patients:

*As a general rule, I actually find the prisoners are sometimes better behaved than a lot of the other patients. I came to realise that nursing prisoners is really, I shouldn’t have any more value judgements than looking after any Tom, Dick or Harry in theatre.*

As the conversation developed, differences in the way Rachael cared for prisoner-patients emerged.
She said:

*I think that I try to not get as emotionally involved with my patients that are prisoners. I think it might be human nature, maybe it’s a bit of a defence mechanism, I would never say to myself that I am a bad nurse because I treat the prisoner-patients a little bit differently to other patients. I mean at times it can be quite challenging, but I’ve never gone home thinking ‘I really should have done this a whole lot differently; I wasn’t as compassionate as I should be’.*

Then later she added:

*I it is hard at times, because I truly believe that I attempt to the best of my ability to treat every patient the same, and I should, but maybe I actually don’t… we have to try our best to be non-judgemental and to treat patients the same, it doesn’t matter what background or where they come from, they all need to be cared for.*

Like Belinda, Rachael expressed egalitarian sentiments and sought to look after all her patients in the same manner. Through reflection, she reconsidered her altruistic ideals and acknowledged that, despite her best efforts, there were some differences in the needs of prisoner-patients.

**Analgesia requirements are greater**

Rachael voiced a belief that prisoner-patients should be treated the same and without judgement. However, in this prejudice Rachael demonstrated how contradictory the experience of caring for prisoner-patients could be. Rachael, along with several of the participants, discussed analgesia delivery to prisoner-patients. Rachael felt at times she was being manipulated; she struggled with deciding what the right thing to do was. Rachael discussed her dilemma:

*I sometimes wonder ‘Is this acute pain or is it just that they like the idea of being up high and stuff like that’, and again I feel as it I’m being manipulated or on the other hand who am I to play God and say ‘no you’re not allowed any analgesia’?*

She said:

*I think that quite often the amount of pain and analgesia required for the prisoners is much greater. Quite a lot of patients are on methadone programs, have been IV drug users while they’re inside the prison system. They should not have access to illicit drugs but a lot of them are going through rehab and trying to get off them. There are some that want lots of analgesia.*
Interestingly, Rachael, like Ella, discussed giving in to the demand of prisoner-patients as an easy option:

_Sometimes, very much with prisoners, whatever they want I just end up giving in to it... I do find it challenging to assess their pain control at times, whether it’s realistic, is it true or are they just hungry for some narcotics?_

Rachael experienced turmoil regarding the adequacy of her nursing assessment, however, Rachael’s expressions were also peppered with sentiments of compassion. Her revelations are relayed in the next prejudice.

**I have compassion**

Rachael held to a belief that there was hope for prisoners to rehabilitate. This enabled her to feel a level of compassion and kindness that was unique among the participants. She suggested:

*I do have a bit of compassion, who knows? There will be people in the system that claim adamantly and quite possibly that they are innocent. I firmly believe that people can be rehabilitated as such and maybe I’ve got this false… I believe in the good of people, so maybe I’m a bit gullible at times. I believe people do make mistakes and do end up in prison for crimes that were just foolish things done as a youngster or stuff like that. Sometimes they are remorseful and there is a chance of being rehabilitated.*

Rachael spoke again of having compassion:

*I think it is extremely important to be non-judgemental because we work in a compassionate environment. We are supposed to have compassion for individuals… when they have surgery they do need comfort, they do need someone to look after them, willing to listen to what they have to say, because it doesn’t matter. If you’ve been a prisoner or not a prisoner, quite often they are scared, they’re scared.*

In a similar way to Belinda’s discussion on prisoner-patients being disempowered, Rachael spoke of prisoner-patients being afraid. This discourse demonstrated her compassionate feelings towards prisoner-patients, as she moved beyond the label to see the person with their vulnerabilities.

Through considered analysis and reflection of Rachael’s prejudices, two horizons evolved. First, **I try to be non-judgemental** and second, **I believe in people**. Rachael’s compassion permeated her discussion, and she expressed **I try to be non-judgemental**. She expressed that she wanted to pay more than just lip
service to her caring relationship with prisoner-patients. On several occasions, she stated that she cared for prisoner-patients *exactly* the same as she did other patients; however, as her dialogue revealed, this was not always the case. Reluctantly, Rachael admitted that equality of care was not always possible. Although less overt than with some of the other participants, differences in her care could still be seen clearly. For example, Rachael stated she kept her distance from prisoner-patients. She pulled back and interacted with them less, sharing less of herself. She suggested that she tried not to get as emotionally involved as with other patients. This experience was highlighted when Rachael discussed analgesia delivery; she made judgements about the prisoner-patients' intentions and honesty when assessing analgesia requirements.

Despite expressing that I believe in people it was evident in Rachael's dialogue that she did not always feel easy with prisoner-patients. Fundamental to her belief system was her belief in people, in the good in people. Rachael did not automatically believe the worst of prisoner-patients; she considered that they might be innocent, might have made some foolish mistake or done something stupid when they were young. Rachael believed prisoner-patients could rehabilitate and move past their current status of prisoner onto bigger and better things. She was willing to sit and listen to what they had to say and take what they said at face value. This belief in the inherent good in people is what enabled Rachael to engage with prisoner-patients in a manner that was caring. She was idealistic and full of hope and this idealism shaped her nursing experience.
Kara

Kara became an employee of the hospital where this study was undertaken as a postgraduate student. At the time of the first interview, Kara had been working in perioperative nursing for two years. Wanting to appear confident to the prisoner-patient was a recurring theme in her discussion; Kara’s dialogue suggested that she did not want to be surprised or put in a situation that she could not control. Kara’s three prejudices as identified through analysis were:

- I put up my guard;
- Half my brain wants to know and half doesn’t; and
- I try to do my best so things won’t haunt me.

I put up my guard

It was very important to Kara that she appear strong and in control and these attributes dictated much of the way she interacted with prisoner-patients. Kara’s dialogue highlighted that the care she gave prisoner-patients was pre-emptive, in that she reacted to things that she thought might happen and called this being on guard. She said:

*I think I put on more of a stronger façade when I meet prisoner-patients. I go in – I’m your anaesthetic nurse, boom, boom. I think that in the back of your head you are always making clear concise questions rather than fluffy questions, because you don’t really want to be having a conversation about why they are in there or how they broke their hand. I do definitely have the guard up.*

I probed further, asking Kara what other things might indicate that she had her guard up. She replied:

*I am less chatty, definitely less chatty; I probably do more assessment from afar. I think sometimes the less you have to fiddle with their blankets or with their drip or fiddle with things they are less likely to get agitated… I think being on guard means looking for signs of those behaviours; you are constantly looking out for that. I guess the gate you have around you might dim that sort of emotional side of nursing somewhat, but I try and care for all my patients the same whether I’ve got the guard up or not.*

Kara claimed she tried to care for all patients the same, yet she suggested she minimised her direct contact with patients, did her assessment from afar and
Findings:

withdrew emotionally or ‘put up a gate’. These descriptions caused me to reflect that she might be frightened when caring for prisoner-patients, so I asked Kara what she was afraid of and why she felt it was necessary to put up her guard. She elaborated:

I think I’m scared that they might blow up because I don’t know what the plan is. They like to know what is going to happen next, what the care is going to be, and that they are going to get enough pain relief. So I think I like to know what the next steps are… I think I’ve got to try to build up my confidence, so if they knock it down a little bit I’ve still got a bit of confidence. I don’t want to fall in a heap the moment that they send out a confidence blow and fall over in a heap or cry or something. You want to make sure you are strong before you start... it’s very hard.

Through this discussion, Kara revealed she felt vulnerable and strongly wanted to remain in control. In a similar fashion to Beth, Kara wanted to get prisoner-patients out of recovery and back to the ward as quickly as possible. This emphasis on moving patients through quickly was related to Kara putting up her guard and wanting to appear confident and efficient. She suggested:

With prisoners you are trying to think about getting everything done so you can get them out as quick as you can, which is probably what we should think about with every patient, it just seems to come onto your mind more looking after prisoners.

I asked Kara why she was in such a rush; she replied:

I guess the more time they’ve got to spin it out, the more time they’ve got to think about just being away from prison. I guess they probably like being out – it’s a different environment, but for us and for all the other patients just for ease of mind I think it’s just nice to have them back (to the ward) as soon as possible…. I guess you want to be assertive in your job, and for them to know that you know what you are doing, caring for them to the best of your ability.

Kara’s dialogue suggested she valued efficiency or speed when caring for prisoner-patients and I wondered if she thought this push for efficiency was detrimental to the nurse–patient interaction.
She replied:

*I try to do the best job no matter who the patient is and I think the efficiency thing actually helps with that, because you are on to it and you are sort of going to treat their pain effectively – be aggressive with the pain management. I guess I do empathise with them to a degree, I do try to make sure that their pain is at an acceptable level and that they are treated with the respect that I would give everybody else. So for them it’s all the same I do for everyone else, but with a slight ‘I want to get this patient back quickly’ in the back of my mind.*

Prisoners playing games and the fear of being manipulated were a concern for Kara. Her dialogue revealed that she felt that prisoner-patients were manipulative – looking to see what they could get from the system such as analgesia, for example. She acknowledged a certain degree of discomfort in her reactions to prisoner-patients:

*I’m sure they all play games, I reckon if I was a prisoner I’d be playing games, I reckon I’d be like ‘oh you know I feel terrible’... I think most people would be scared of being manipulated by them. I guess being on guard means looking for signs of those behaviours; you are constantly looking out for that. I think in normal patient care you are not thinking that patients are manipulative, whereas you might think that more of a prisoner, which is horrible really when you think about it. When I say it out loud, I think ‘oh that’s not very nice, you know, here we are condemning them to being completely different to everyone else’.*

And then later:

*If you are just sort of looking after a patient you don’t think that they are going to try and pull the wool over your eyes; but with these people, I guess I am always aware that they might do that... I guess you don’t want to get them upset, I don’t want them to get upset – ever. I don’t want the guard to have to get out his whacker.*

Kara’s care of prisoner-patients was heavily influenced by her wanting to be in control and her being on guard for potential situations that might destabilize that control. One aspect of wanting to be in control was a curiosity to know the prisoner-patient’s crime. This curiosity is explored in the next prejudice.

**Half my brain wants to know and half doesn’t**

Kara talked about the impact of knowing the prisoner-patient’s crime. She revealed that when she did not know the crime it gave rise to speculation and fear.
She said:

\[
I \text{ am curious, I think half my brain wants to know and half doesn't want to know. I don't really know what they did and most of the time I'd rather not know.}
\]

She added:

\[
\text{Half the time we don't know what they did: I mean, they could be just people that made a mistake in life really, down to the real nasty ones as well. I think it's fear of the unknown, because you don't really know what they did.}
\]

I probed her comment further and asked Kara what she was worried about. She responded:

\[
\text{I guess there's always a bit… you never know what they've done, which, I like it like that. But you can never know if they've beat up little kids, or they've been manipulating women, or if they've murdered someone. Like you just never know what they're capable of… But then there's other people out there who haven't been caught but with the same thing. I just never want to push the boundaries to find out. I am happy just cruising along. I guess everybody has a little bit of fear about (prisoners) because not only for yourself but also for all the other patients in the recovery room at the time and all your colleagues. But I don't think they're really able to do much. I think you probably watch a little bit too much television if you think they're going to do too much, but there has been one trying to escape in this hospital.}
\]

Kara continued, talking about a situation where she did find out the patient’s crime. She said:

\[
\text{I found out afterwards, I found out afterwards by mistake. Everyone was talking about it because one of the surgeons found out and 'I don't want to know' and then someone told me by accident, and I feel like I would rather have not known. I think if you don't know what they did, it is easier to treat them just like normal human beings.}
\]

**I try to do my best so things won’t haunt me**

Kara spoke of trying to do her best when caring for prisoner-patients. This point was highlighted when she spoke of analgesia delivery. Kara often dwelt at home on things that had happened over the day, pondering on whether she had done the best she could.
She explained:

I think with all my patients I want to make sure that their pain is at an acceptable level and everything is settled. I don’t think that I compromise that with prisoner-patients. That’s the sort of thing that I can’t stop thinking about – if I let them go and I knew they were in pain. Or if I knew they weren’t feeling quite well. Unless I have already done absolutely everything that I possibly could do, then I personally can’t stop thinking about it, then it plagues my life.

She continued:

Often I go home and think about my patients, think about the day. If there is something that hasn’t gone quite to plan, it can haunt me for the entire night. And I don’t want my experiences with prisoners to haunt me, because I don’t like any of them to haunt me, but sometimes they do. Sometimes you just dream the entire day, you relive it.

Kara gave an example where thoughts of what a prisoner-patient did bothered her. She said:

I’ve had a situation where I’ve done CPR on a prisoner and you don’t really want to think about them being a prisoner when you are doing CPR. All you want to think about is that they are a person and you are saving their life, and that’s all you want to think about. You don’t want to have ‘oh this man was a child molester’ or something in the back of your mind, I’d rather not know.

Kara identified that it was important for all patients to be treated with respect. However, she placed limits on the boundaries of her respect.

She explained:

Everybody has the right to voice and feel pain. Everybody has the right to the same sort of treatment whether they are a prisoner or not. I try and do the best job no matter who the patient is… I want for them to know that you are caring for them to the best of your ability. They are all humans and that’s all that I really want to know… it is all about respect. It’s about ‘I’ll treat you and I’ll respect you as long as you respect me’.

However, she tempered this ideal when she said:

I think I’m different while I try not to be.

Like myself, Kara found the experience of caring for prisoner-patients compelling and haunting in a way that stayed with her and influenced her nursing care.
Embedded in Kara’s dialogue were significant prejudices that shaped her experiences with prisoner-patients. These prejudices were developed into the following two horizons: **it is important to be confident** and **I restrict care**. As can be seen from her dialogue, Kara considered **it is important to be confident**. Kara strove to give care that was efficient and detached, and carried out in a confident manner. Kara experienced some fears. She was concerned about the prisoner-patient reacting in a negative manner, becoming agitated or ‘blowing up’. She was also concerned that the prisoner-patient might manipulate her, ‘play games’ or ‘pull the wool over her eyes’. Kara did not want to look foolish; fundamentally, she wanted to be seen to do her job well. This need to appear confident manifested itself in several ways. Kara aimed to be efficient; she developed a plan of care with prisoner-patients that involved minimal interactions and dialogue. Kara liked to be organised and to know what was going to happen next so she could pre-empt problems. Her aim was to return the prisoner-patient to the ward as soon as possible but, in doing so, she restricted her care.

On analysis **I restrict care** was evident in Kara’s dialogue. She had high expectations of herself and her nursing care. She aimed to deliver nursing care to prisoner-patients in the same manner that she did with general patients, yet she openly held back on her care – Kara spoke of observing prisoner-patients from afar, fiddling less at the patient’s bedside and generally keeping her distance and spending less time interacting with prisoner-patients. Kara kept her guard up; maintained a façade, which resulted in care that was formal and restricted. She was less chatty and not as friendly with prisoner-patients, and she suggested she dimmed the emotional side of her care with them. Kara believed prisoner-patients deserved the best care she could give them. However, the focus for Kara when saying this was on performing activities of nursing care without **caring for** prisoner-patients in the same manner as other patients. Kara had high expectations of her care delivery and, when she reflected on her care if she considered she could have done something differently, she was filled with remorse.
Tracey

Tracey worked in the perioperative area with prisoner-patients for sixteen years. She considered her Christianity to be fundamental to her nursing care and ultimately she believed in the good in people. However, this did not mean her experience of caring for prisoner-patients was without challenges. What permeated Tracey's dialogue was the way she perceived herself as a nurse, as shown through her five prejudices, which were:

- Experience helps;
- I look after them as a person;
- I feel vulnerable at times;
- I never want to know; and
- I guard up and judge.

Experience helps

Experiences that happened to Tracey nearly twenty years ago significantly impacted on her as a person and on her nursing practice. She revealed how her practice changed and grew, when she said:

I am much more happy and relaxed now. I've been here sixteen years and it's not such a big thing. With some of the experiences I've had before, I've learnt to speak to prisoner-patients.

She elaborated:

I think just the experience, my age as well, being older and having children, the whole experience of knowing how to deal with another person. I think just that general nursing experience of caring... it is challenging, but I definitely think the experience of looking after quite a few [prisoner-patients] now has definitely helped.

Tracey relied on her life experiences to assist her to interact with the prisoner as a person. This was her goal and is explored further in the following prejudice.

I look after them as a person

Tracey expressed it was important to look after the person and to ignore their status as a prisoner. She considered that she could make a difference by caring about the prisoner-patient on a personal level, not just focusing on her nursing
activities. In a manner similar to Rachael, it was very important to Tracey, both as a nurse and as a person, to be compassionate and give the prisoner-patient the benefit of the doubt from the beginning. She relayed:

*Patients seem a bit vulnerable or embarrassed coming in, they know they’ve got all this attention, ‘everyone knows who I am’ and then straight away you can see in their faces, some will be defensive maybe to the point of being rude. We are the first point of contact, let them know they’ve got someone here who’s looking after them as a person, not judging them as a prisoner and I can see a change in some of them. When I go up and say ‘hi I’m Tracey I’m here to look after you today’ or even when they get their drip put in I’ll still hold their hand or look at them and say we’re nearly done with that. I can see a change straight away and I think it’s how… we can make that change because everyone is really antagonistic I’m sure they can feel if anyone doesn’t really want to look after them.*

While most participants spoke of putting barriers between themselves and prisoner-patients, Tracey focused on breaking the barriers down:

*That’s good to see when you’ve got someone who can break that barrier down. I think for us as nurses, if we can break that barrier down, we are not here to judge them, we are here to look after them. There are some that won’t change, but we can help with a bit of that communication we like to have with our patients and trusting.*

Later she continued to discuss further her ideal of herself as a nurse and the differences she could make in someone’s life. She said:

*I think as a nurse it’s nice to look back later and think ‘I have looked after all patients in the same light, same way’. To walk away and think my care of that particular patient, he would at least think that that was an experience that was not horrible. Other things that he might be involved in, everything could be horrible but when you come to theatre to have surgery we all have that vulnerability inside. I think sometimes that might show as anger, defiance or whatever to try to be brave and yet they are all still scared. I think as a nurse to be able to connect with that patient the same as everyone else I feel that I am happy that I have done that, all revolves around being non-judgemental and just being a nurse and being with the patient when they have their surgery.*
Tracey's religious beliefs underpinned first her ability to connect with prisoner-patients, and second her nursing philosophy, which was that everyone deserves care:

*I'm religious. I go to church and I think my faith makes it easier for me to look after them. I think that the religion side of it helps us to be able to deal with it and I think helps me… it should really be a part of us all the time and maybe the ones of us with faith and religion find it easier.*

She further suggested:

*When I observe other people and their reaction and their anger and things. I wonder if they have any values like that to help them understand why we look after these people here?… I do not find it hard because of the religion, not that I've ever really thought of it.*

Fundamentally, Tracey embraced Christian ideals and strove to connect with prisoner-patients. However, despite the goal of making a difference in the lives of prisoner-patients, aspects of caring for them challenged Tracey. She expressed concerns that, despite her best intentions, she would not care for prisoner-patients fully and in the manner she desired. One concern discussed was feeling ‘vulnerable at times’.

**I feel vulnerable at times**

Notwithstanding Tracey having considerable experience in caring for prisoner-patients, she expressed fear at times when caring for them. She considered the question of what might potentially happen if a prisoner-patient became violent.

She said:

*Straight away, you think ‘prisoner, I'm scared', it's the first thing.*

Tracey provided an example of when she felt threatened:

*I was being threatened by the patient, and it shook me a bit. The guards thought because he [the prisoner-patient] went to go to the bedrails to come out [climb out of bed] they came straight across thinking he was going to hurt me or attack me or whatever. So that shook me a bit because I thought... you just sort of forget sometimes [that the patient is a prisoner] because it’s just the patient, even though the guards are there.*
I asked Tracey if she was frightened in that situation:

> Just for that brief instant, for a minute because what I thought straight away and assumed it was going to be... made me think 'gosh it could have been bad'.

For Tracey feeling vulnerable was mitigated by the presence of the guards, who gave her a sense of being safe.

> Security, you felt a bit vulnerable, the guards were still with you and everything... someone had tried to escape with a prisoner or had broken out, a bit before I came here and I remember hearing about it. There is the underlying thing that they could still have other issues, perhaps violent... I'm glad to know the guards are right there and they're aware too as the patient's waking up. When they're handcuffed to the bed, knowing they can't get out, I feel OK with that.

Like Belinda, Tracey discussed feeling that the workplace should be like a sanctuary, safe and secure. Tracey relayed an experience when there was a prisoner who had escaped elsewhere in the hospital. The initial story that was communicated to the operating theatre staff was that this prisoner was on the run. This made Tracey question the safety of her workplace and she felt vulnerable:

> It's amazing how when you hear that, knowing it was the prison ward, you straight away feel vulnerable. Actually, we work here, and we have a prison ward here, what if someone else came in or escaped. I think everyone sort of talked of that for a while. I'm thinking of my family, my family are at home and I've come here to come to work today. How safe are we here if this has happened this time?

Feeling vulnerable was one element of caring for prisoner-patients Tracey found challenging. Another was the impact that knowing the prisoner-patient's crime had on her goal to treat prisoner-patients as a person and make a difference.
I never want to know

Tracey was concerned that knowing the prisoner-patient’s crime could influence her ability to deliver impartial care. She offered:

> You feel guilty, because you think ‘I shouldn’t be thinking that, knowing’, that’s why I’d rather not know. If that guy is lying there because he’s a prisoner, because he is a murderer, or he is only just in jail because he got caught doing tax or something like that, I want to just treat them the same. Sometimes we have a more high profile patient, someone that you know from the news. That’s I think even harder, because they’ve already got this stigma, you have read a lot about them in the paper. But I think again, you have to do the same. I try to do the same, stepping back and being the nurse, and thinking he’s my patient I’ve just met.

Tracey relayed an example where knowing the patient’s crime really caused her inner turmoil and made her second-guess her decision to give the patient analgesia. She said:

> I’m giving him morphine and still at the back of my mind I was thinking… cause I knew. I shouldn’t have known he killed someone, and I’m looking after him you know. I never want to know now, because I think I don’t want it to influence my care, because we do tend to judge people… when he had pain I had to give him something for pain, you think someone died… and I don’t think I need to know all that sort of stuff, if the patient’s in pain I want to be there, ease him right then and there.

Tracey found prisoner-patients had poor coping and communication skills at times, especially in relation to having pain and needing analgesia. She was empathetic to their circumstances and was able to excuse poor behaviour. She explained:

> I find with most of them its pain that’s the problem. If I’ve got a patient who’s a bit aggressive and some are. It’s always gloves, goggles, because someone spat once… some prisoners do it because they’re restricted in handcuffs, they can’t get their emotions out. They might have had pain really, really bad and they feel that they’re not getting adequate analgesia, even though we’re giving the requirement, they don’t handle it, stuff like that, and some of them have spat.

Tracey made concessions for prisoner-patients and their analgesia requirements and was quite relaxed in her attitude. The decision to give analgesia and worry less about the prisoner-patient’s motives was something Tracey developed with experience.
She explained:

I don’t know, I think their threshold of pain, like they need more pain relief... sometimes I probably learnt in all pain just keep giving more and not worry so much. I think we’ve all learnt more with pain relief. So yeah, they’re in pain as much as anyone else and they have the right to be comfortable, don’t they? I think [they do].

Knowing the prisoner-patient’s crime interfered with Tracey’s ability to connect with them. So, she worked towards being focused in her care. And yet she, like many of the other participants, was emotionally distant at times in her interactions with prisoner-patients.

I guard up and judge

It was important for Tracey to acknowledge that she was very happy to look after prisoner-patients. However, she did discuss keeping a distance emotionally, rather than physically. She said:

I don’t feel any different looking after them as opposed to someone who’s not [a prisoner-patient], except maybe just guard up a bit to talk to them, but not in terms of being ready to talk to them, not saying I don’t want to look after them.

Tracey was guarded and did not give much of herself. In our conversation, she said:

You don’t want to give too much of yourself. Likewise, by finding out more from them, you don’t want to cross that line in the same way; it might lead to them wanting to ask about your family and things. You can still look after them, be polite and have a basic conversation.

There were also other times when she mentioned being guarded and maintaining a distance from the prisoner-patient. She said:

When they come in handcuffed to the trolley, not all of them are handcuffed, but I have seen some of them come handcuffed and the gun was very prominent on the guard. As soon as you see that when you are checking them in, the guards were right at the bedside, they didn’t want to leave. I was a bit more guarded that time, cause then you think ‘oh he must be a really high-profile serious offender than someone else’ but then again I will still try, step back and try and do, but it is like in the back of your mind.
Findings:

Tracey indicated awareness that she had a job to do, although she had some apprehension and wanted to keep her distance. Despite her best intentions to not judge and to make a difference, Tracey acknowledged that at times she judged:

*I think maybe you do judge… not judge them but you know when you look after someone and they’re a prisoner you think straight away they could have HIV, they could have hep C, you put gloves on and you start making assumptions.*

Tracey was one participant whose focus was on meeting the needs of the person, looking behind the label. She demonstrated a significant level of empathy and compassion and yet there was distance and judgement interwoven into this.

After deep contemplation and analysis on Tracey’s experiences, the horizon I elicited for Tracey was ‘love the sinner, not the sin’. This ideal permeated Tracey’s experience. Tracey’s religious beliefs grounded her in compassion and humanity and she tried to impart these values throughout her professional life. Tracey valued her role as a nurse and her experiences of nursing were closely aligned with her religious beliefs. When encountering prisoner-patients, Tracey experienced some challenges to implementing her goals of nursing care. She tried to treat the prisoner-patient as a person, get beyond the label and break down barriers and meet their individual needs.

Tracey struggled with inappropriate behaviours such as bad language and spitting of some of the prisoner-patients; however, she felt she needed to connect with the individual patient and believed she could see a change in her care when she achieved this connection. There were elements of her experience which challenged Tracey’s ability to connect with prisoner-patients in the manner she desired. These were feelings of vulnerability, making judgements when she knew the prisoner-patient’s crime and keeping herself emotionally distant. When Tracey was unable to meet her goals of care for instance if she found herself judging or pulling back, she felt guilty. Tracey asked herself how people without faith coped with the experience of nursing prisoner-patients, because she found the experience to be easier to cope with because of her religious beliefs. As Tracey said, it broke down to being a nurse and just being with a patient.
Ryan

Ryan was the least experienced of the participants, having worked in the perioperative area for a year at the time of our interview. Shortly after his interview he left to travel and, consequently, his observation and second interview were not completed. From Ryan's dialogue, his prejudices were:

- I get a vibe from the guards;
- Male nurses get more prisoners;
- Prisoners are drug seeking; and
- Prisoners are generally OK.

I get a vibe from the guards

As Ryan had very little experience of caring for prisoner-patients to build on, he took his cues for the care of these patients from the guards. He associated the guards' behaviour with the security threat of the patient. As Ryan suggested:

_I get a vibe from the guards. Just when they start putting handcuffs on and how they treat the patient, or if they joke with them. The guards sometimes sit back and read their magazines, flick through and the patient remains un-handcuffed the whole time until they're about to leave. In some cases, the guard is pretty much by the bed and as soon as the airway is removed, they put the handcuff on and make sure the patient is secure. They always talk to the patient and tell them what to do, tell them to be quiet, to do this, so I just assume that they're [prisoner] more of a risk._

Ryan's interaction with the prisoner-patient was restricted if the guard was in close proximity, which indicated to Ryan the prisoner might be difficult and potentially cause him trouble. Generally, Ryan seemed willing to chat with the prisoner-patient, although he was aware that there were limitations imposed by the presence of prison guards and his awareness of the patient's status of prisoner. Ryan explained:

_I chat, more with them when the guard is sitting back reading his book. If the guards up at the bedside I don't, more probably because the guard is sitting there. I leave the patient to be quiet and leave them to do their job. If the guard is not there then I start chatting. I know the difference is that you can't really ask them what they've been doing, but and I do try and ask them about sport or stuff like that._
Ryan made some value judgements about the patient based on information he considered reliable, the prisoner guards. He also considered that, as a male nurse, he was expected to care for prisoner-patients more frequently than female nurses, a point that will now be discussed.

**Male nurses get more prisoners**

Ryan felt that, as a male nurse, he was allocated to care for more of the prisoner-patients than his female counterparts. Andrew, the other male participant, mentioned this also, when Andrew spoke of being 'lumped with patients no one else wanted'. Ryan’s own experience concurred with this:

> I’ve noticed that we [male nurses] might get more of the prisoners which is fine, but I noticed prisoners all of a sudden think or assume you’re a doctor before you’re a nurse. Actually like four times I tell them ‘no I’m a nurse’. I think they might treat you differently just because you’re a guy and they see girls as different, lower in nursing, so they treat us differently.

**Prisoners are drug seeking**

Ryan identified that prisoner-patients, unlike general surgical patients, were denied access by anaesthetists to drugs of addiction such as morphine for pain relief:

> The prisoner is asking you, ‘What have I got?’ ‘How much can I have?’ So you’ve just got to try and say, ‘How bad is your pain?’ without letting on they’re having morphine. When they’ve got knowledge, and a background of usage [I.V drug use] the anaesthetist says ‘try and not use morphine as much as possible’. I think they [the anaesthetist] are wary, like morphine is the last resort.

Ryan continued:

> They are more reluctant to go with those drugs, because the patient is just seeking drugs… another hit or plus some pain relief.

Ryan generally found prisoner-patients to be generally OK; which is explored in the following prejudice.

**Prisoners are generally OK**

Ryan’s general experience with prisoner-patients was that they were well-behaved patients. However, there was also an underlying concern that they could get angry.
He suggested:

Most prisoners are quiet, respectful and helpful and thankful for the care you've given them and things like that, as opposed to someone who's come in from the street who's a drug user, quite abusing and demanding. I find the prisoners quite good and relaxed most of the time… Their behaviour, they might do something spontaneous like pull something out if they get angry, I suppose that's the only real difference… I find they are put further away [in the back of the room] than other patients.

Ryan asserted that he treated prisoners no differently; their prisoner status did not have any impact on his care but, in his dialogue, he described the nursing process as being routine and without frills. He suggested:

I don't take any notice that they're a prisoner. I just treat them as I would [any patient] when they come out. I'll go through the same steps, treat them the same way, and give them the pain relief that they're allowed and require and then get them upstairs... I assume they've all done something wrong to be in jail. It doesn't really matter what they do, they've all done something enough to be in there. It doesn't really affect how I treated them.

And when speaking of his observations of other nurses, Ryan said:

I think with prisoner-patients they focus on the nursing activities...maybe they don't deserve getting looked after as much... I have noticed handovers aren't in as much depth... I think some people treat them bad, like 'do the care, send them upstairs'.

In a subtle way, Ryan demonstrated his care of prisoner-patients was different and judgemental. As Ryan explained:

I'll put gloves on, although I don't put gloves on with every patient but now I'll make sure I put gloves on if it's a prisoner.

Ryan suggested that it took a bit more of an effort on his part to ensure prisoners received the same level of care as other patients. However, during busy times or when he was stressed, he mused that he would take his frustrations out on prisoner-patients. He said:

I try probably harder when I have a prisoner to make sure it is even. But it depends on how busy you are and how your day has been too. If you get a prisoner late in the afternoon and you've had a crap day the whole day and you've had a few annoying patients you'll probably take it out on that [prisoner] patient.
Ryan considered the implications of feeling tired and worn out, expressing that concentrating on the technical aspects of care was not good enough. He said:

_I think once you've got just the activity side of nursing then you should just leave, cause you're just concentrating on the technical side and not the caring, looking after the patient being the main goal and responsibility, then maybe you should take time out and leave. The patients' mood and how they feel is just as important as the nursing activity side… if that seems too frustrating then you are just burnt out… sometimes you get that impression that it doesn't really matter as much. They [prisoner-patients] are not as important as the other patients._

I thought about Ryan’s experiences and, after deep consideration, developed the horizon: **I don't think about it too much.** This horizon reflects Ryan’s experience of caring for prisoner-patients. His actions were influenced by the attitudes and actions of others, such as the prison guards. If the guards were relaxed and joking around the patient, Ryan assumed the prisoner-patient was less of a risk than if the guards were more attentive. Ryan did not verbalise the same level of concern or anxiety about the prisoner-patients’ crime that many of the other participants. His experience focused on taking the prisoner-patient at face value as much as possible. He did not describe concerns about what might happen or what the prisoner-patient might have done in the same way other participants did.

In the first section of this chapter, I revealed the prejudices that I brought to the study, and by explicating these prejudices, I endeavoured to make clear my own pre-understandings and attitudes that influenced my understanding of the phenomenon of caring for prisoner-patients. This is an essential element of any study based on a Gadamerian philosophy. It is from this foundation that I incorporated the experiences of the participants adding depth and layers of understanding to my understanding of the complexity of caring for prisoner-patients. I identified prejudices for each participant, and supported these by excerpts of the participants’ dialogue. Finally, I identified the horizons for each participant that were embedded in their dialogue, and drew together their experiences. Next, I fuse the common understandings or horizons that are found across all the participants’ experiences.
Fusion of horizons

Fusion of horizons is a metaphor for understanding. A fusion of horizons occurs when one integrates another person’s viewpoint into one’s own view (Gadamer 2004). In the current research, I considered deeply the experiences of the participants when caring for prisoner-patients and sought to draw congruencies in the experience and highlight the diversities. I utilised several techniques to enable an expansion of my own horizons and to fuse them with the participants’ horizons to enable greater understanding of the experience of caring for prisoner-patients. These techniques included such things as:

- asking participants to clarify or refine the ideas they expressed that I did not immediately grasp;
- carefully identifying and considering the horizons they expressed and sharing these with the participants to determine whether they rang true;
- constantly thinking about how to make meaning about what was said;
- reflecting on what each participant had said and how it could be understood in relation to others; and
- integrating and expanding my initial horizons with those of the participants.

In the next step of the analytical process, I fused my horizons with those of the 12 participants, to develop a new understanding of what it was like for registered nurses to care for prisoner-patients within an acute care environment. The five fused horizons are:

- registered nurses give prisoner patients perfunctory care;
- caring for prisoner-patients is emotionally draining;
- prisoner-patient care is reactive;
- knowing or imagining a prisoner-patient’s crime creates practice dilemmas; and
- expressions of care straddle real and ideal caring perspectives.

I fused the horizons of the participants for the purpose of developing a new understanding of a phenomenon under consideration. This does not imply that all
Findings:

participants had the same understanding or agreed on the impact of that experience when caring for prisoner-patients. Rather, the fused horizons encompassed multiple realities of the participants’ experience, which provide fresh insights into phenomenon of registered nurse caring for prisoner-patients.

Registered nurses give prisoner-patients perfunctory care

All participants spoke of caring for prisoner-patients as being perfunctory at times. ‘Perfunctory’ was used to convey the sentiment that care was given as a duty, was mechanical and provided out of obligation, without affection or genuine feeling. Throughout my engagement in this study, I conceptualised care as having the elements of motivation, caring for the patient, caring about the patient and forming a caring relationship. The term ‘perfunctory care’ describes care that is constrained or lacking an emotional component or caring about someone, for a variety of reasons. The participants all experienced that, while they provided care, they either detached themselves emotionally or placed an emotional barrier between themselves and the prisoner-patient, to protect themselves from physical or emotional harm. Hence, while taking care of prisoner-patients, nurses performed physical nursing tasks but they did not engage in caring for or about the patients.

Andrew’s discussion focused on delivering non-judgemental nursing care, that was entrenched in a philosophy of care but his dialogue was devoid of discussion of caring elements. He focused on automatic routine aspects of care giving which he referred to as ‘implementing care’; Beth had a strong sense of the value of caring for and caring about patients, but found she was unable to connect with the prisoners on an emotional level because she didn’t like them. Her care was restricted, devoid of warmth, touch and genuine interaction. Ella described genuine caring for prisoner-patients as impossibility, overall Ella believed the ability or desire to care is innate and governed by human nature. Ruby felt dissatisfied with her inability to develop a rapport with prisoner-patients’, feeling that she gave less of herself; and Sarah blamed her professional efficient attitude for her physical and emotional distance, which she believed was necessary for her safety. Prudence differentiated between her public and private personas, her empathy and compassion were notably reduced; while Julie delivered automated, activity-focused care that on occasions she could move beyond. Belinda’s care was wary and rudimentary, characterised by reduced interaction and less rapport, and she
had a keen awareness of the difference in her care between prisoner and non-prisoner patients. Both Rachael and Tracey’s enactment of care was less perfunctory than for the other participants but, nonetheless, permeated their practice in subtle yet significant ways. Tracey was guarded while trying to be warm and Rachael admitted she was hesitant with prisoner-patients and seldom was self-disclosing although she normally was with other patients. Kara was blatant and openly restricted in her care, she strove to be efficient at all times and, finally, Ryan acknowledged differences in his care of prisoner-patients and the effort it took to address the inadequacies in his care.

When I asked myself how each participant's unique and individual expressions contribute to the fused horizon perfunctory care, I concluded that their caring was constrained in the nurse–prisoner-patient dynamic. While their dialogue revealed that each participant cared for prisoner-patients differently, the descriptions of the care they provided implied, blatantly for some and subtly for others, that they gave care but were not caring. The declaration that these participants provided regarding their caring practices with prisoner-patients belie many tacit assumptions that underpin registered nurse practice, for example all nurses are unequivocally caring, this is an important point and it will be elaborated upon in the discussion section of this thesis.

I found that the dialogue of these participants echoed the experiences and observations I identified when I commenced the study. However, through our dialogue, my understanding of the caring dynamic broadened. Initially I believed in care as a natural response and I realised that, for the study participants, the caring ideal, as documented in literature was not achieved, which has implications for the way caring is expressed and described in the literature, taught in education programs and enacted in practice.

**Caring for prisoner-patients is emotionally draining**

The participants found that caring for prisoner-patients was an emotionally draining experience. It was an experience that did not come with the same ease or as instinctively as most other nursing care interactions. There was a cost to the participants to participate in the nurse–prisoner-patient relationship; for some, the cost was perceived as being so great that they did not engage with prisoner-
patients in any real sense. For others, the cost contributed to feelings of dissatisfaction with the care they provided and ultimately distrust of themselves as nurses. The experience was one which stayed with the participants and over time, these memories shaped the future interactions participants had with prisoner-patients. This was not an aspect of the experience of caring for prisoner-patients that I had considered prior to the commencement of the study. Although I indicated that I did not like being told whom I should like and engage with, discursively I considered that the nurse–patient relationship should be one of free choice, not expectation. The weight of expectation, on reflection, is an aspect of the care of prisoner-patients that I identified as emotionally draining. When I reflected on the participants’ dialogue I developed the fused horizon caring for prisoner-patients is an emotionally draining experience.

Through their dialogue Andrew actively sought to care for prisoner-patients in a non-judgemental manner and tried to do the right thing, but as he said being non-judgemental took considerable effort. Beth found the physical care of prisoner-patients draining and the emotional experience taxed her. She said that, if she allowed herself to care, she would not be able to work. Like Beth, Ella kept distant from prisoner-patients to minimise the emotional cost; otherwise, she considered she would become broken. Ruby provided subtle indications that she withdrew emotionally from prisoner-patients, suggesting that she found the care of prisoner-patients easier, when she was less emotionally involved. Ruby also invested a significant amount of emotional energy to maintain her ideals of equality in health care. Sarah kept her distance from prisoner-patients both physically and emotionally, as she was fearful for her safety and her emotional wellbeing. When Sarah felt vulnerable, intimidated or out of control, she described that the experience became emotionally draining. Prudence pulled back her emotional involvement and wore a mask with prisoner-patients, as she said she went through the motions of giving care but never let herself feel any emotion. Julie considered the experience stressful and needed to constantly reassure herself she was okay; Belinda acknowledged the extra emotional effort it took to care for prisoner-patients and asserted her right to disengage; Kara found herself haunted by her interactions with prisoner-patients; and Tracey relied on her religious beliefs to support her. Finally, Ryan was able to explore the care of prisoner-patients if all was going well, but failed if he was stressed or having a bad day.
Findings:

When I considered all that was discussed about the emotionally draining elements of prisoner-patients’ care, I was surprised by the diverse and innovative ways in which the participants attempted to manage their emotional wellbeing; however, this management was often at the cost of patient care and this point will be picked up again in the discussion chapter.

**Prisoner-patients care is reactive**

Nurses do not practise in a vacuum; they have many influences which affect the nursing environment. ‘Reactive care’ is a phrase I use to capture the experience of how these registered nurses enacted care of prisoner-patients in response to their socialisation, stereotypes and judgements. Verbalisations of the nurse’s view of the patient as different and their response to this perceived difference, the influence of the guards on the nurse–prisoner-patient dynamic and opinions and socialisation from other colleagues, all coloured the experience of the nurse and their ability to enact their caring role. The nurses responded to these external influences in a manner that was reactive, often lacking in reflection and deep thought and often in opposition to what they believed good nursing to be.

Andrew constantly struggled to not judge prisoner-patients. He addressed this battle in a forthright manner, which distinguished his experience from many of the other participants. Beth believed prisoner-patients were stigmatised, and that people always expected the worst of them, she used words like violent, aggressive, hard and intimidating to describe them. Ella was openly judgemental, and was unashamed and blatant in her position that she had a right to judge prisoner-patients. Ruby’s care was reactive to both the patient and the guards; Sarah judged the prisoner-patient as either nice or nasty and reacted accordingly. Prudence revealed initially she allowed stereotypical views of prisoner-patients to heavily influence her, although her reactions were tempered by experience, Julie expressed concern about her safety based on the way the prisoner-patient looked. Kara’s responses to prisoner-patients were based on fear and she put her guard up and put on a strong façade when she first met prisoner-patients. Belinda acknowledged she was wary of prisoner-patients from the outset, which caused her to be guarded in her interactions with them. Rachael and Tracey expressed their maturity helped them in the long run to become comfortable caring for prisoner-patients. However, even these participants expressed at times they felt vulnerable
which interfered with providing compassionate care and finally Ryan frankly admitted his care cues were taken from the prison guards.

In summary, the fused horizon prisoner-patient care is reactive identifies that the participants’ responded readily to some influence – either to external elements or their own emotional state. What was unique to each participant’s view of prisoner-patients related to the impact these external influences had on their capacity to care.

**Knowing or imagining a prisoner-patient’s crime creates practice dilemmas**

All participants discussed the impact of knowing the prisoner’s crime on their ability to deliver nursing care with all points on the continuum expressed, from never wanting to know the crime to always preferring to know and be fully informed. The impact that knowing had on their ability to deliver care also varied, from considering that the prisoner-patients’ crime had a significant impact on their ability to deliver care to suggesting it held no bearing at all. The general consensus was that it was easier to pretend the prisoner-patient was like any other patient if you were unaware of their crime which facilitated the participants ability to deliver nursing care. I asserted at the commencement of the study that knowing the prisoner-patients’ crime would make a difference to care delivery. But what I did not fully comprehend was the depth to which participants were affected by this knowledge. The power of knowledge of the prisoner-patient’s crime was pervasive and unavoidable, no matter how strongly the participants embraced positions of ethical neutrality. What was surprising was the potential for damage to the nurse–prisoner-patient relationship by mere imagination of what the crime might have been. Concerns about what the crime might have been loomed large causing much angst. Very few participants actively sought information about the prisoner-patients crime but prisoner-patients who were responsible for the most heinous and reprehensible acts were well known to nurses through media coverage, the judicial process and reports of the impact on their victims.

Andrew tried to be non-judgemental when engaging with prisoner-patients despite knowing their crime, but his care lacked warmth. Beth initially struggled to feel any compassion or even like a prisoner-patient but on reflection she actively sought to
change this. Ella was frank about the impact that knowing a prisoner-patient’s crime had on her ability to care, a response she attributed to human nature. Ruby, never knew a prisoner-patient’s crime, but said if she knew the prisoner-patient had hurt little children or raped innocent women she would not want to help them as much. Sarah was adamant it was her right to know the prisoner-patient’s crime so she could be fully informed. Prudence found herself restricting her empathy and care as a result of knowing, while Julie had the experience of completely shutting down emotionally in response to a prisoner-patient’s crime. Belinda believed knowing changed the person she was, and Rachael’s experience was one of valuing the prisoner-patient as an individual, an experience she found easier to do if she did not know the crime. Tracey relied on her faith to enable her to meet with prisoner-patients in a real sense yet expressed straight away you think prisoner, I’m scared. Finally Ryan asserted the prisoner-patient’s crime had little effect on him, he assumed they’ve all done something wrong because they are in jail.

The impact of knowing the prisoner-patient’s crime it was an aspect of caring for prisoner-patients that was significant and defining of the experience. This knowledge influenced the participants’ who struggled to meet their ideal nursing goals, which are further elaborated upon in the next fused horizon.

**Expressions of care straddle real and ideal caring perspectives**

The participants’ discourse reflected that they experienced conflict between their ideal view of what nursing should be and the reality of their experiences when caring for prisoner-patients. The nursing ideals were not the same for each participant and each had a particular view of how they wanted to enact their caring role. Nurses are guided by ideals in practice and try to live by these ideals but in difficult care contexts these nurse participants struggled to meet their own expectations of what a good nurse is and does.

Andrew expressed an ideal of being non-judgemental in the care of this prisoner-patients yet in doing so he separated his feelings from his actions, a position he did not seem to be aware of; Beth revealed that she knew she treated prisoner-patients as prisoners, a position she regretted, and Ella mentioned her ideals of nursing were unattainable when caring for prisoner-patients. Ruby and Julie both expressed they were not relaxed when caring for prisoner-patients; Sarah’s focus
was on herself as an individual and her rights; whereas Belinda’s focus was on society’s responsibilities and our nursing obligation to care for all humanity. Prudence and Kara held the ideal of meeting the prisoner-patient’s physical needs with no obligation for any emotional input and considered by meeting the physical needs they were fulfilling their role; juxtaposed to this were Rachael’s thoughts on the importance of compassion and Tracey focusing on the needs of the individual patient. Finally, Ryan held as an ideal the combination of nursing activities and attitude to deliver compassionate care.

**Succinct statement**

From a Gadamerian perspective knowledge develops when multiple realities intersect and create new understandings; which he expressed as fused horizons. As the researcher, the final step of analysis for this complex phenomenon was to develop a succinct statement of what it was like for the participants and myself to care for prisoner-patients. I used the five fused horizons to develop the succinct statement which is:

Table three: Succinct Statement

**Succinct Statement**

Caring for prisoner-patients is an **emotionally draining experience** where knowing or imagining a prisoner-patient’s crime subtly provokes registered nurses to give **reactive and perfunctory care** that **straddles real and ideal caring perspectives**.
Chapter summary

In this chapter, I presented the findings that emerged through analysis of the dialogue of 13 participants, including myself. Through the process of hermeneutic analysis, I developed prejudices and horizons for each participant. I also present five fused horizons that encapsulated the experience of a registered nurse caring for prisoner-patients within an acute care environment. Finally, I developed a succinct statement that expressed the complex phenomenon of registered nurse caring for prisoner-patients. Through these activities I provided insight into a care situation that is difficult and demanding on many levels.

My understanding of the phenomenon of caring for prisoner-patients has expanded through being immersed in this research. From the outset, I believed that registered nurses cared for prisoner-patients differently from other patients. While the dialogue of the participants seems to confirm this assertion, it is important to note that not all participants were aware that they enacted a subtly different kind of care when interacting with prisoner-patients. This finding has important implications for how we immerse ourselves and engage in critical self-reflection on and in our practice. I contend that if we are to grow as nurses, we must develop critical insights into how we conduct ourselves professionally, particularly as it relates to delivery of our care. The experience of caring for prisoner-patients is a complex one, full of contradictions and unmet expectations. The participants placed a great deal of pressure on themselves to meet their expectations of what nursing meant to them and these points will be further elaborated on in the discussion chapter of this thesis.
Chapter Six:

Discussion
Introduction

In this chapter I commence with a brief discussion on the study methodology and method. With the advantage of hindsight I consider the value of the choices I made and discuss how I grew through engagement with this study. I continue the chapter by explicating the participants' experience of caring for prisoner-patients, drawing in salient literature when appropriate. Through analysis of the participants’ dialogue the complexity of the phenomenon of caring for prisoner-patients is unveiled; not only with regard to these registered nurses' experiences of prisoner-patient care, but also with regard to the caring dynamic in more universal terms.

Discussion of the study methodology/method

My decision to structure this study using Gadamerian hermeneutic phenomenology enabled me to obtain data that was rich and complex and which elicited the phenomenon of registered nurses caring for prisoner-patients. Whilst I am pleased with the choices I made, in the course of my engagement in the study, when I reviewed the interview transcripts I became aware that I had limited interview experience. On occasion my lack of experience resulted in lost opportunities to probe more deeply into the participant's world and their lived experiences. While this is regrettable and I acknowledge that with additional experience I may have done further justice to exploring the issues the participants presented, I consider that my experience as a PhD student was one of learning new skills and gaining insights into the complexities of engaging in qualitative research. To my credit I was gratified to note that my interview skills improved for the second interview, and I was pleased that I included this data collection strategy, because it provided a second chance for me to clarify meaning and to distill the essence of the phenomenon of registered nurse care for prisoner-patients. On the whole, I remain firm in my belief that undertaking a Gadamerian hermeneutic phenomenological study was the right choice for me, and also the right means to explore this complex phenomenon for the reasons given in chapters three and four. These included my familiarity of the research phenomenon, the type of rich and descriptive data I was seeking, the value of context and an inductive style of analysis.

To my surprise I experienced minimal direct benefit in observing the participants’ practice. While I was aware of the Hawthorne effect (Wickstrom & Bendix, 2000), I presumed that because observations were spread out over a period of
approximately 18 months that participants would eventually get used to my presence. Instead, what I found was that their behaviour did not always match the descriptions they provided during their interview of their caring practices, and they appeared to try hard to engage prisoner-patients while I was observing them. With further reflection the process of observation was implicit to my understanding and developing fused horizons with the participants. It consolidated my insider journey and my relationship with the people and environment in which we work. It could be argued that the observation process and the research project itself precipitated change in the climate of the post-anaesthetic care unit and stimulated attention to the care of prisoner-patients. It brought practice issues to the fore and promoted inter-collegial discussions of their nursing care experiences. This focus led to heightened emphasis on prisoner-patient care and encouraged the development of a reflexive environment. This became more obvious during the second interview as many of the participants, although consistent with their key thoughts on the experience of caring for prisoner-patients were more reflective. While these were not expected outcomes of the study I welcomed the change that occurred to morale in the unit while the study was being undertaken.

The observation process also stimulated discussion during the interview sessions where events that had been observed were the seed which generated discussion. This indirect benefit of the process was valuable and led to anecdotal discussions from which deeper understandings were gleaned. Occasionally, the observation process resulted in a direct discussion about particular participant practices such as when a participant suggested their usual practice was to remain at the bedside of all prisoner-patients, which would be usual practice with non prisoner-patients. As I had not observed this behaviour directly I was able to question further and this probing resulted in further reflection by the participant.

There were incongruencies between my experiences of honest and frank discussions that occurred during interviews and the contrast with what I believed were more contrived practices during the observation periods. I have no real explanation for these events other than to note that the interview conversations did not always begin in the open manner in which they concluded. The discussion expanded over time and superficial dialogue gradually receded. Perhaps with increased time the observation process would have undergone a similar evolution and been more beneficial and less contrived as a data gathering tool.
I found many benefits to engaging in journalling throughout this research project. Smyth and Holian (1999) recommend journalling as a tool for the researcher to confront perceptions and assumptions. They suggested that with reflection, learning and awareness develop in a reflexive manner. From a Gadamerian approach to understanding, where history and context are central to the process, I affirm that journalling was an important element that aided in identifying my preconceptions and prejudices and facilitated understanding of the changes that occurred in my thinking. Journalling provided perspective and enabled me to track my progress when fusing horizons with the participants. This is interesting because maintaining a journal was the one element I struggled with the most throughout the data collection phase. I found it difficult to see the relevance of my musings early on, but in hindsight it was an invaluable tool that added to the trustworthiness and transparency of the process of gaining understanding.

**Insider Research**

Stemming from my decision to adopt a Gadamerian approach to understanding was the challenge to construct the study in a way that acknowledged my status as an ‘insider researcher’. Insider research has been defined by Kanuha (2000) as “research in which scholars conduct studies with populations and communities and identity groups of which they are also members” (p. 439). This definition well describes my situation, where I was known intimately by the research participants and where I had insider knowledge of what it was like to care for prisoner-patients, factors that I acknowledged in the method chapter of this thesis.

Insider research has both benefits and potential hindrances to the research process. In general terms those who have written about insider research suggest the benefits are that the process is perceived as more authentic, whereas outsider research, where the researcher is not known to; or is a part of the group, is considered by some to be free from bias (Allen, 2004). A significant consideration is, as Allen suggested, that polarizing these two positions is too dramatic. In reality no one is totality familiar in an environment or by contrast totally strange. Opinion as to whether insider research is valid, or has value, is mixed. Smyth and Holian (1999) considered it ‘worthwhile and useful’; and Reinharz (1992) suggested that human research *should* use the researcher as a research instrument (authors emphasis). Others (Bonner & Tolhurst, 2002) acknowledged its limitations, such as the tendency of an insider researcher to make assumptions or the familiarity of
some behaviours (including your own) making it hard to identify them. From a Gadamerian perspective conducting insider researcher fits well with the premise that the researcher is contextually bound to the research environment and that knowledge construction comes from a situational perspective.

In my experience there were many benefits to researching within my own environment, as well as some limitations. There was honesty in the dialogue I exchanged with the participants; in part due, I believe, to having already established relationships of friendship and trust. I also believe, as does Smyth and Holian (1999), that I was able to offer unique perspectives on the experiences that were directly related to my knowledge of the organisational culture, environment, social structure and the history involved, factors that are congruent with Gadamer’s position on how knowledge is constructed. Van Heugten (2004) referred to this familiarity as ‘privileged understanding’. Another benefit was my knowledge of language, slang and jargon used by the participants which enabled me to usually grasp what the participants were expressing without having to clarify meaning (Jacobs-Huey, 2002).

With regards to the limitations of researching in my own environment, a potential existed that participants had a desire to please, or to impress me, which may have distorted their descriptions of caring for prisoner-patients. This was somewhat evident in the observational process where I struggled to identify authentic behaviours. Additionally participants could have focused on particular issues while minimising those that were perceived as less desirable. This was not something I believe occurred during data collection. I found participants readily disagreed with me, and directed the content of the conversation. Further the richness of their shared thoughts, which on many occasions deviated from idealized descriptions of nursing practice, led me to conclude that the participant’s revelations were both honest and frank. One thing I became fully aware of when transcribing the text was that the sharing of past experiences with participants resulted in details being omitted from their descriptions. Phrases where used such as ‘you know what I mean…’ or ‘you remember the time…’ This limited the richness of the first telling of the participant’s stories which I was then able to rectify at the second interview.

Some might argue that vulnerability could have concerned the participants because I did not remove myself from the environment as other researchers do following data collection periods. The information participants shared, remained within the
local context, which may have been close to home for some. Additionally, it also
needs to be acknowledged that the findings or results of this study will eventually
be published or at least made public in some form. This has the potential to make
the workplace uncomfortable for the researcher and/or the participants because
some findings are uncomplimentary to the organisational values or the hospital.
Indeed the findings may offend individual nurses or the profession as a whole.
Jacobs-Huey (2002) suggested that insider researchers need to be particularly
sensitive to the dangers of revealing or uncovering secrets and airing what the
group may consider ‘dirty laundry’. I am attuned to this recommendation and have
taken every precaution to mask the identity of the individual participants and also
the hospital.

Finally, power imbalance is a consideration in all research environments, and is
particularly significant when researching within your own environment. This power
may or may not be something formally recognised within the organisation but
irrespective it places pressure on the quality of the information obtained.
Traditionally, the balance of power has been seen to rest with the researcher
(Franks, 2002), however, at times, particularly during data collection the power can
be seen to rest with the participants as they can refuse to discuss issues, cancel
appointments or withdraw altogether (Cotterill, 1992). I believed power
considerations were addressed within the consent process; and interestingly I
experienced a feeling of powerlessness while waiting for nurses to consent to
participate, hoping that they would.

**Critique of the study findings**

Discussion now focuses on the participants’ experience of caring for prisoner-
patients, highlighting gaps, parallels and divergences with the literature. Issues that
arose from the study findings are offered and the findings are woven together with
the key concepts presented in this chapter

**Care without compassion**

Adopting a task centered approach to care was the norm for many participants;
these practices are described more fully within the fused horizon perfunctory care.
For example, Jenny spoke of nursing from a checklist and several other
participants such as Andrew and Beth discussed a task focused approach to
prisoner-patient care. Using this activity based strategy rendered their care for
prisoner-patients soulless. The finding that the participants’ gave prisoner-patients perfunctory care reinforces Pask’s (2001) assertion that if we only talk about care in terms of jobs being done, the meaning of care is gradually eroded and we do not experience it in a full moral sense. On the surface if one provides ‘care for’ an individual but does not ‘care about’ an individual this can, to a certain extent be masked, albeit temporarily. Prudence certainly attempted to mask this type of caring without compassion by suggesting she had different feelings on the inside, which she tried to hide. As did Ella who referred to going through the motions of care, giving the impression that she was engaging with prisoner-patients but in reality she withheld the emotional component, as she said ‘feeling like a cow on the inside’. Practicing within a ‘care for but not about’ ethos makes patient engagement incongruent if not impossible. Put more simply, engaging in perfunctory care negated possibilities that the registered nurse participants could authentically and genuinely form a compassionate relationship with their prisoner-patients which ultimately was detrimental to the prisoner-patients care experience.

Roach (2002) suggested caring is the locus of all attributes used to describe nursing. She asserted:

Caring is not simply or exclusively an emotional or feeling response. Caring is a total way of being… in which one expresses the self fully and through which one touches intimately and authentically what it means to be human (p. 39).

Most of the participants struggled to enact any semblance of this all encompassing expression of care. The experience of the participants as discussed, was that they restricted their emotional responses while providing care and consequently did not experience what Roach suggests is care as a total way of being. Further, in literature some suggest the relationship between a nurse and patient results in a spiritual, intimate, esoteric and awe-inspiring connection (J. Watson, 1988). But as illustrated throughout the participant’s dialogue, most of the participants did not have a spiritual connection and some did not hold a positive regard for their prisoner-patient with some struggling with even the fundamentals of a caring interaction. A question that this raises and perhaps implies is that they did not care? Several of the participants discussed not liking prisoner-patients, and not feeling empathy. However, they worked hard to focus on the tasks of care and considered that the tasks minus emotional engagement or relationship were still care. The humanness of these participants was seen in their struggle to negotiate what it meant for them to be a nurse and maintain their humanity. There was
significant inner turmoil involved in their experiences as they toiled to enact all aspects of care as it was identified in the literature review, as an action, an attitude, requiring motivation and a relationship.

**Caring: possibly an obscure relationship**

What is apparent when one adopts a ‘care for but not about’ way of enacting one’s practice is that it creates distance both emotionally and physically (Barry, 1996) which is prohibitive to the development of a caring relationship. The exact nature of a nurse–patient relationship in the context of prisoner-patients warrants further discussion. It has been offered that to care necessarily involves engagement in a relationship (Stockdale & Warelow, 2000), but what form that relationship takes to be considered caring is not readily apparent. At one end of the continuum, this relationship is described in its most basic sense as merely an exchange between two people (H. Smith & Smith, 2008). However, at the other extreme, which resonates with the general consensus of care offered in nursing dialogue, is that the nurse–patient relationship is fundamental to the caring experience (Austgard, 2008; McQueen, 2000) with reciprocity imperative (Hoagland, 1990). Brown, Kitson, and McKnight (1992) assert the caring relationship assumes people meet together and experience mutual positive regard between carer and cared for. There is no doubt in ideal circumstances a goal for nurses is that of establishing a deep connection with their patients, and this aim is usually held in high regard. Yet, the more idealised the definition of a caring relationship is, the more remote the ideal appears when considered in light of these participants’ experience. There is scant explanation of how a nurse–patient relationship or partnership actually exists: and further, discussion is warranted about the expectation that it should (Muxlow, 1995).

What resonated as true for nurse–prisoner-patient interactions and the experience of the participants was an unsolvable quandary which was how they could achieve balance between intimacy and distance. This balance, described by Robinson (1996) positions nurses as compassionate strangers and this idea is also discussed by Brown et. al. (1992), who suggested a balance of intimacy versus distance is an ethical dilemma:

> Our own ethical dilemmas come when we begin to unpack some of the paradoxes in ordinary caring and professional care, in traditional and realistic images of nursing and in the choices we as individuals are constantly making between involvement and detachment, therapeutic-use-of-self and self-protection, between
authenticity and manipulation in every caring relationship we experience (p. 49).

The description of the ethical push–pull in caring relations is salient to the experience of the nurses in this study. Clearly participants made choices about the level of engagement they embraced with prisoner-patients. However, there was also an aspect of the nurse participants’ interaction which they described as evoking a tacit and innate response. This response was aligned to their gut reaction; which several participants such as Ella and Prudence argued, was outside the realm of choice.

A question that could be considered is was the claim that their response was outside the realm of choice an excuse for not confronting their reaction? Was it safer for the participants of this study to subconsciously place their response outside of their locus of control? It is possible and yet there were occasions where despite their best intentions participants described an involuntary reaction. Julie for example spoke of shutting down emotionally when she discovered the prisoner-patient’s crime and she expressed regret in her reaction but claimed she could not help it. Belinda also generally tried hard to engage with prisoner-patients, but also had an experience of reading the prisoner-patients notes which interfered with her intentions once this information was discovered.

Gadow (2003) suggested the relational narrative is a means of moving beyond judgement to create a connection that the nurse and prisoner-patient experience in a positive manner. The relational narrative requires engagement as the basis of a combined journey between the nurse and the prisoner-patient. Engagement entails an understanding of each other’s position, nurse and patient. Both the nurse and prisoner-patient Gadow asserted, may need to alter their view in order to connect with the other. However, the capacity to alter one’s view of the other, Gadow suggested, offers an extreme test of the relational narrative as prisoners can be seen as having a view or position the nurse is unlikely to be able to connect with. However, in working together to establish some common ground, both the nurse and the prisoner-patient will benefit and be able to establish a relationship that is in both their best interests. This description of undergoing a combined journey was not the experience of the participants of this study who may have been able to negotiate common ground with prisoner-patients on occasions, but also gave many examples of being unable to connect and at times having no desire to do so. Often this lack of desire to connect as was evident from the participants transcripts was
an overriding fear, fear that had some very real roots with the presence of guards and guns but also fear that was imagined such as stories of escape and harm.

Implicit in the notion of forming a relationship is an expectation that the parties concerned have a part to play. Inherent in this suggestion is a claim that a recipient of care must be willing to respond to the one caring, to disclose information about themselves and how they want to be helped (Brown, et al., 1992). There is an assumption in much of the literature that patients desire a relationship with the nurse who provides their care, and while this may be generally true, it is possible, as Curzer (1993) asserted, that the patient may also resent the need to become an object of significant emotional attachment in order to receive care. The patient may want to keep to themselves and not engage with the nurse for a number of reasons. However, by not responding, the patient runs the risk of not being liked or perceived as worthy of care or affection by the nurse. Many of the participants of this study held a belief that prisoner-patients did not deserve their care or may not desire their care for their surgical recovery. If this is the case then prisoner-patients care needs may be ignored, particularly if nurses systematically make themselves unavailable (emotionally) to prisoner-patients. Alternatively, given that literature identifies that prisoner-patients often seek out health care as a means to relieve the boredom of incarceration (Willmott, 1997) it is possible that prisoner-patients might desire or seek out a relationship with nurses (albeit temporarily) while in hospital. However, the dialogue of the participants of this study does not support or refute Willmott’s assertion. In any event a relationship may never come to fruition particularly if nurses remain emotionally closed and distance themselves from prisoner-patients.

The findings of this study suggest that the nurse–patient relationship is not static and I suggest that universal statements that hold the imperative to care as sacrosanct are fraught with problems and ought to be questioned. Clearly it is not appropriate for a nurse to withhold physical acts of care in any situation, or to become punitive; however nurses should be able to make individual choices appropriate to their journey, about the level of emotional connection or relationship they engage in with a prisoner-patient. Descriptions about the nurse–patient relationship and the boundaries that frame this relationship are imprecise and not clearly explicated within the literature (Lotzkar & Bottorff, 2001; Muxlow, 1995). The experience of the participants in this study highlights these uncertainties, in
particular both the precise nature and the cost of caring, suggesting that contextual aspects of the caring dynamic require further consideration.

**Touch as connecting**

As I discussed, a recurrent motif that expressed the perfunctory nature of prisoner-patient care was closeness and distance, both physically and emotionally, experienced with prisoner-patients. Evidence of distance was highlighted through the participants’ revelations of touch or non-touch of prisoner-patients. It is well established that touching is an integral part of human life; humans are touched and touch others throughout their lives (Benjamin, Werner, & Chellos, 2009; Hayward, 1999; van Dongen & Riekje, 2001). Touching is a form of communication and it is accepted that physical touch is an implicit, essential and universal component of nursing care, that nurses touch within a caring perspective (Benner, 2004; Chinn & Kramer, 2008; Hayward, 1999).

Touch is enacted in several different ways by nurses. It can be seen as a purely task-orientated activity, as a necessity to achieve a procedure, to implement care, which is referred to as instrumental touch (Chang, 2001). Instrumental touch is the type of touch most frequently employed by the participants of this study. Healing touch, is in itself healing by utilising natural energy balancing processes within the body (Leder & Krucoff, 2008; J. Watson, 2008). Notably comfort touch, which is described by Watson (2008) is touch that demonstrates an emotional connection and is used to comfort and reassure. This type of touch was lacking from the practice of the nurse participants of this study. Other expressions of touch mentioned within nursing literature and described by Chang (2001) include touch to alleviate pain and fear, touch for orientation, proactive touch and touch to convey an interest. Again, this type of touch was rarely expressed by the participants of this study.

Touch is discussed by Patricia Benner (2004) who identified the notion of disclosive spaces. This space, she suggested, was the social space created in human relationships and interaction, and is descriptive of the goal for nurse–patient interactions. In a disclosive space it becomes possible to disclose and notice some things and not others. Touch and comfort, Benner offered, are central to creating safe and therapeutic disclosive spaces. Edvardson, Sandman and Rasmussen (2003) had similar ideas regarding a special space, suggesting that touch creates a
bubble around the nurse and patient where the patient has the nurse’s undivided
attention.

The creation of a space in which the nurse and prisoner-patient could engage was
not often experienced by the nurses involved in this study. In fact many participants
expressed they preferred to pull away and remain distant. Julie however, spoke of
wanting to make the interaction just about herself and the prisoner-patient, alluding
to a desire to create a therapeutic space. She believed this intention was thwarted
by external influences such as the presence of guards. Connor and Howett (2009)
and Benner (2004) both suggest that fear and suspicion are barriers to the creation
of a nurse–patient relationship that impede the development of a disclosive space.
Given that the participants of this study voiced they felt wary, (Andrew, Prudence
and Belinda), and had concerns that the prisoner-patient might hurt them (Sarah,
Beth, Julie and Kara), it is reasonable to speculate that their caring practices were
shrouded by fear making it difficult if not impossible to enter into a therapeutic
nurse–patient relationship.

Crosby (2001) who ran informal community education programs, wrote that
distancing the self from others is often used for ones protection, either emotionally
or physically. As far back as Menzies-Lyth (1959) and more recently Holden (1991)
and Crosby (2001), there are suggestions that when nurses wish to reduce anxiety
in situations they automatically distance themselves from their patients. Kruijver,
Kerckstra, Bensing and van de Wiel (2000) described a study comparing different
touch in the clinical setting. They found that nurses used blocking behaviours, such
as distancing and avoidance, when their work became too stressful or when they
were faced with problems they felt they could not cope with. Interestingly, this
description mirrors the experience of many participants of this study who distanced
themselves from prisoner-patients

The benefits of overcoming suspicion and fear, and engaging in touch and caring
practice with prisoner-patients, is in the acknowledgement of the patient as a
person and connecting with them on a deep level. For most participants of this
study however, seeing the prisoner-patient as a person was rare. A notable
exception to this was found in the dialogue of Ella who admitted that sometimes
nurses get a glimpse of the real person making the experience worthwhile.
Poignantly, touching or not touching symbolised the varying extremes of closeness and distance experienced by the participants during their care of prisoner-patients. Most participants acknowledged that they did not physically touch prisoner-patients. This realisation came as a surprise to some, as it was not something they consciously decided to withhold from prisoner-patients or thought about in a deliberate manner. Rather, once identified, they believed this non-touch practice to be an unconscious response. Their experience of not naturally or spontaneously touching a prisoner-patient could be considered akin to descriptions of care as a natural or innate response.

The participants’ experience did not reinforce descriptions provided in the seminal work of Noddings’ (1984) on ethical care, as their experience was that, while they were able to carry out caring activities, they were unable to pretend to care about prisoner-patients in any real sense. Noddings argued that the impulse to care is innate; however, she believed that when this impulse was absent, one could draw on a sense of morality and care irrespectively. I suggest that it would take a very mature, well-grounded individual to balance issues of intimacy, trust and distance; and this assertion is well aligned to perspectives offered by the participants of this study.

If touch is considered a cornerstone of caring as suggested by Block (2005) then what does non-use of touch by these participants signal to prisoner-patients? Should non-touch be construed as a visible sign that nurses regard prisoner-patients as unworthy of their care? Or should non-touch be considered as a self-protective mechanism that nurses use when interacting with prisoner-patients? These questions are raised because they are important and herald the need for further exploration into the complex phenomenon of registered nurse care for prisoner-patients and the meaning that touch may or may not convey in the caring dynamic.

Notwithstanding, not all the participants’ expressions were parsimonious when speaking about touch. Tracey discussed touch as an example of how she broke down the barriers experienced between her and prisoner-patients, when she spoke of sitting on their bed and holding the prisoner-patients hand as a means to convey closeness. As with not touching, the impetus to touch a prisoner-patient was an unconscious action; as suggested by Ella, who was surprised when she placed a hand on a prisoner-patient’s shoulder because, as she acknowledged she did not
normally touch prisoner-patients. The hospital experience can be depersonalising for patients, especially for prisoner-patients, as was recognised by Tracey. To touch prisoner-patients is to affirm that they are a person rather than an object, and to communicate the value of caring as a basis of nursing actions (Fry, 1989). The participants of the study often expressed views of the prisoner-patient as having little value, in particular if their crime was known and confronting. Lack of touch was a symptom of devaluing and, by not touching and keeping distant; the participants did not seek to affirm the prisoner-patient as a person of value in any way.

Edvardsen (2003) contends that touch transforms nurses in several ways. Touch acts as a catalyst and enables nurses to see themselves as valuable, with the power to ease suffering. Connor and Howett (2009) believe that intentional touch has a reciprocal quality, which positively benefits both nurse and patient, which suggests that intentional touch could enable nurses to reduce their suspicion and fear of prisoner-patients and increase their connection with prisoner-patients. Encouraging the nurse to see the patient as a human being facilitates a relationship between the two. Both Tracey and Ella spoke of the benefits of touch in their care of prisoner-patients and their experiences could be used as a catalyst to promote discussion about the use of touch within the unit where this study was conducted.

The participants also verbalised a concern for the prisoner-patient’s response to touch; some participants stated they did not want to be intrusive. Sarah did not believe the prisoner-patient wanted to be touched, nor did she think touch was necessary for her to do her job. The perception that prisoners are tough and emotionally reclusive is a concern. While the intrusiveness of unwanted touch must be avoided, it is imperative that this does not prevent comforting touch (Benner, 2004). Connor and Howett (2009) suggested that some patients are “touch hungry” (p. 128) which is a term used to describe individuals who are seldom touched in adequate or appropriate ways; it is possible that prisoner-patients are touch hungry and unable to communicate effectively, and so hide behind a tough exterior. This further restricts the development of a nurse–prisoner-patient relationship.

Developing relationships, trust and using touch are aspects of caring for prisoner-patients that have the ability to reduce the perfunctory nature of the experience, and yet the nurse participants found it difficult to embrace the fundamental philosophy which values the nurse–patient relationship as a human mode of being
(Roach, 2002; J. Watson, 2008). As discussed in the literature review Roach (2002) considered care as a way of living that fosters freedom in all relationships, moreover that care is the reason the human race has survived. However, Roach also suggested that our culture is more often known by its absence of caring in current times, due in part to a loss of an emotional connection with the world. The lack of connection is next discussed with reference to the cost of caring.

**The emotional cost of caring**

The participants of this study found the experience of caring for prisoner-patients to be emotionally draining. In my journal I touched on the emotional impact of the experience when I referred to my emotions being “used up”. The participants concurred that the experience of caring for prisoner-patients was not easy; the care of prisoner-patients cost the participants significantly on an emotional level, for example Kara was haunted at times by her experiences with prisoner-patients, Beth spoke about how hard it was, that the physical care was hard enough, implying that the emotional care was unattainable. Ella considered the potential that she would become emotionally broken by the experience if she engaged in authentic caring. The extent of which the participants were impacted was surprising, despite my knowledge of the seminal work of Hochschild (1983) on emotional labour. It is important to note however, that although the participants, myself and Hochschild all acknowledge the emotional cost of caring there is also potential that not caring is draining and is costly. Not caring can also be exhausting, a burden, and equally emotionally challenging.

Discussion in the literature provides only a cursory exploration about the impact on the nurse of complicated and demanding patient-care situations. The findings of this study suggest that caring for prisoner-patient’s is illustrative of a complicated and demanding situation, which made the nurse participant’s position untenable at times. An aim of this research was to explore how the nurse participants coped with the challenges associated with emotionally challenging care contexts. It was apparent that over time, the participants developed several ways to respond to emotional pressure, and used a variety of defence mechanisms and coping techniques. One example was the development of a manufactured emotional state, such as Kara’s overt efficiency or Sarah’s ‘professional’ distance. These types of responses Herdman (2004) argued are a result of living in a post-emotional society where emotions and actions are separated.
Coping techniques adopted by the participants

There were a number of defense strategies employed by the participants to facilitate their interactions with prisoner-patients and to reduce the emotional strain of some patient encounters the participants perceived as difficult. These included the use of distance, professional aloofness or efficiency, inner voice and game playing such as assuming the prisoner-patient was admitted for non-payment of parking fines. While literature makes mention of this, suggesting that “in reality nurses use a number of defensive strategies to shield themselves from the anxieties they experience when working with patients who may be suffering emotional physical or spiritual crisis” (Mackintosh, 1999, p. 325), little has been written about shielding the self when experiencing internal anxieties such as fear when caring for prisoner-patients.

In a study of forensic nurses in the United Kingdom, Walsh (2009), identified four key relationships: the relationship with the prisoner-patient, with the institution, between the nurse and prison guard and finally the internal relationship the nurse has with themselves. This notion of an internal relationship with oneself was also evident with participants of this study when they listened to their inner voice as a coping mechanism to enable purposeful engagement with their prisoner-patients. The participants who utilised this technique did so to facilitate their interactions and care of prisoner-patients by consciously modifying their behaviour. Examples of this practice could be seen with phrases such as those repeated by Andrew, “it’s not for me to judge” or “play it cool” which was a mantra used by Julie, to influence her own emotions and behaviours. Participants spoke of difficult situations suggesting “I just tell myself” or “I keep repeating to myself” when there were attitudes or behaviours they considered needed modifying. This repetitive dialogue reminded the participants of the type of persona they wanted to adopt.

Archer (2000) explored the connection between our internal voice, our emotions and our personality. She suggested the use of reflection monitors and reviews our emotions, which are articulated through inner voice. One can feel emotion in response to an event, for example, disgust when nursing a patient who has committed a heinous crime, and then modify that response as a result of reflection. In this example, the nurse may have a conversation with the self reminding them that the patient is a human being who needs respect and compassion like any other, and alter their external response with this in mind. For example, Andrew
repeated to himself “it’s not for me to judge” when he encountered a prisoner-patient who challenged him philosophically, in an attempt to put his judgements aside, he repeated the phrase and used this reminder to actively modify his behavior. Whereas Belinda on reading a patient’s history felt herself shut down on discovering the prisoner-patient’s crime and was unable to modify her response in this way.

Nurses can undoubtedly be held responsible for their behaviour, but whether the nurse can or should be held responsible for their emotions is an interesting question. Behaviour, as previously discussed, can be altered through the use of imagination, inner voice and memory, among other things. It is through the “conscious training of habitual responses” (Pask, 1997, p. 51), that nurses come to be disposed to respond and to act with compassion. Emotions, however, are less easily manipulated. While some believe emotion cannot be controlled (Pask, 1997) others argue that an emotion may not be controllable but the response to the emotion is a choice (Theodosius, 2008). Certainly, many of the participants believed their emotions were innate and uncontrollable. For example, Prudence said “I wish I didn’t feel that way but I do”, and Ella said “it is what it is” when talking about her response to prisoner-patients. Ella and Prudence, among others, were adamant that they could not change their emotional response. In Ella’s example, she attributed her attitude to human nature, something out of her control.

Crawley (2004) conducted a study with prison guards which resonated with the experience of the study participants, which identified coping techniques prison guards used when caring for prisoner-patients. Crawley suggested that the prison environment is an emotionally challenging one and, that prison officers use humour, tell stories, play parts and stage-manage their actions in an attempt to control how they are perceived by prisoners and colleagues. Correlations can be seen between this type of behaviour and the experience of the participants in this study, who also practiced similar forms of emotional management. The potential danger with humour and storytelling is its close relationship with disrespect of the prisoner-patient personally, and the potential for objectification of the prisoner-patient and depersonalising them, as seen with the defensive strategy ‘othering’ (Peternelj-Taylor 2004).

As discussed in the literature review Peternelj-Taylor explored ‘othering’ as a defence strategy and a negative form of engagement with prisoners within
correctional and forensic nursing. Placing prisoner-patients in a position of ‘other’ was evident in the participants’ dialogue. Ella expressed her care of prisoner-patients was easier if she could see herself as ‘other’ – as better than them, and removed from their situation. Participants also used slang such as ‘rough’, ‘mean’, ‘big’ to describe prisoner-patients. Ruby spoke of differences in her care when she perceived the prisoner-patient as ‘good’ or ‘bad’. The dichotomising of prisoner-patient’s into ‘us and them’, ‘good and bad’ restricted the participants’ ability to engage with the prisoner-patient in any real and meaningful way. Canales (2000) posed that placing the self in the position of the ‘other’ enables one to view the world of others from their point of view. On a cautionary note I contend, that Canales suggestion can be fraught with danger for nurses because while it is important to consider the prisoners position as patient, this should be done without fully embracing the prisoner-patient’s world view. In some situations, such as the nurse–prisoner-patient relationship distance may be required to facilitate the nurses’ ability to care for the prisoner-patient or to protect the nurse from harm.

Reacting to difference

Notably the participants of the study were not always able to utilise coping techniques to positively influence their care of prisoner-patients. It has been suggested that caring nurses are supposed to be able to “sublimate their negative feelings in order to maintain ethical standards” (Holmes, Perron, & O’Byrne, 2006, p. 310). Yet this was not always achieved by the participants of this study. They responded to aspects of the prisoner-patient’s situation in a reactive manner, which will now be discussed.

At the commencement of the study I was curious because, when asked, my colleagues responded that they believed they cared for prisoner-patients in the same way that they cared for other patients. Throughout the study, particularly when analysing the content of the interviews, I was struck by both contradictions in the participants’ dialogue and dialogue that did not support this assertion. Sarah, for example, expressed that the patients’ status of prisoner made no difference to her care, that she was able to separate the patient from their crime. However, her dialogue was peppered with examples of judgement and verbalisations of negative feelings. She referred to prisoner-patients as dangerous, intimidating and disgusting and yet offered that she did not pass judgement on prisoner-patients. When I identified the participants’ prejudices, I acknowledged that, although
individuals appeared to disagree with themselves at times, from a Gadamerian perspective this is natural because all understanding unfolds over time and is indicative of the complexity of one’s experience.

The nurse participants reacted to prisoner-patients in both positive and negative ways, despite a desire to treat prisoner-patients in a non-judgemental manner. Nurses responded to the prisoner-patients often in negative ways as a reaction to aspects of the prisoner-patients’ persona, the way they looked or behaved and their memories of past experiences and hospital myths. The participants clearly reacted to aspects surrounding the experience of caring for prisoner-patients, such as the guards’ presence, logistics, as well as the prisoner themselves. The participants also responded to the prisoner-patient in positive ways if their impression was favourable and they believed the prisoner-patient to be ‘nice’.

On one level the nurse participants believed they had a responsibility to care for patients unrestricted by considerations of socioeconomic status, personal attributes or the nature of the health problem; as Belinda said everyone is entitled to health care as we live in a dignified society, or Ruby offered that prisoner-patients deserve the best care we can give. In reality the nurses found fulfilling an obligation to care problematic when they perceived the patient as difficult, challenging or even threatening. They were not able to sublimate their negative feelings or practice ethical care in many situations.

Maeve and Vaughan (2001) discuss a penal harm perspective to prisoner-patient care where they assert that nurses contribute to the notion of punishment by withholding care in some way. Perhaps it is timely to consider that withholding care is a social injustice that nurses can inflict on prisoner-patients and that fundamentally the caring relationship needs to move beyond judgement. There was some evidence of the participants trying to maintain a non-judgemental approach. Ruby considered prisoner-patients are already being punished for their crime as they are serving time, and in this way attempted to be non-judgemental. Andrew considered the possibility that the only difference between a prisoner-patient and any other patient is that they had been caught. What was evident from this research, however, was the nurse participants agreed that they ought to use a non-judgemental approach with prisoner-patients even while verbalizing that their care was discriminatory.
The participants’ judgements about prisoner-patients were based on pre-conceived stereotypes. Commonly held assumptions about prisoners are that they are violent, use drugs and try to manipulate the system for their own benefit. For example, many participants assumed prisoner-patients were exaggerating their pain to gain access to analgesia. Participants also made assumptions based on how the prisoner-patient looked, equating a certain image with aggression. Often the participants were aware of their stereotyping, an example when Prudence remarked, tongue in cheek, “you think because they are big and covered in tattoos that they must want to hurt you”. On one level Prudence believed that what she was saying was true, yet she provided no concrete example where this belief was supported in practice.

Stereotypes are a necessary aspect of our social world (Peters, Jelicic, & Merckelbach, 2006) which we are dependent on to reduce our processing demands (Falkenberg, 1990; Peters, et al., 2006). Without stereotypes life would be chaotic and difficult to navigate. We use stereotypes to define group membership (Hinton, 2000), with the abilities and attributes of certain individuals considered typical of all members of the group (Eagly & Steffen, 1984). Stereotypes about nurses; nurse as the ministering angel, nurse as the sexy siren are examples (David, 1991). However, this embedded, generic nature of stereotyping can lead to inaccuracies and negative consequences (Hinton, 2000) because they are generally based on relatively little information and are used as an excuse for social injustices.

It is noteworthy that literature identifies that stereotypes cannot be eliminated from practice and, once held, they are very difficult to change (Hinton, 2000). Adjustment to one’s beliefs occur very slowly and only after significant perception-altering events. For example, if a nurse holds a belief that all prisoner-patients are aggressive, such as Sarah believed, it would take only a few aggressive patients to reinforce that belief: whereas it would take many well-behaved gentle prisoner-patients to alter the belief, if it could be altered at all. I suggest that stereotyping can be viewed as a coping mechanism of the nurse participants, as they expressed they had a better understanding of prisoner-patients and their situation in life when clinging to pre-held assumptions. However, nurses who ascribe to stereotypes fail to develop an understanding that grows through empathetic and in-depth appreciation of events (Pask, 2001) and also fail to meet the patient as an individual. Jean Watson (2008) wrote that caring necessitates accepting an
individual not only as they are now but also the person they are becoming. Caring, Watson asserted is inviting the emergence of the human spirit, which was not realized by some of the participants who negated both their own spirit and their patients at times.

Liking or not liking a patient is an aspect of caring that is well documented (Hellzen, et al., 2004; McMillan, 2000; Rondahl, Innala, & Carlsson, 2004; Russell, Daly, Hughes, & Hoog, 2003; Shinn, 2002); but there is scant attention given to the specific circumstances that surround the giving of prisoner-patient care. Thoughts on the caring discourse which resonate with the experience of caring for prisoner-patients are seen in ideas on caring offered by McCance (1997) who stated “for nurses to like all patients they care for, let alone love, is a difficult idea to comprehend...one does not have to like an individual to care for them but can respect them as a human being with freedom to choose” (p. 245). In a similar vein Crosby (2001) emphasised the value of respect, offering that respect is possible without a positive regard. However, Crosby continued, to have respect without positive regard requires significant self-awareness on behalf of the individual caring. The participants expressed difficulty in even liking a patient at times, and certainly in many situations found it difficult to rise above their initial instincts of distrust, an aspect that is rarely discussed in the caring literature.

Several authors suggest that feelings of care for patients occurs spontaneously (Johnstone, 1989; Kuhse, 1999). It would stand to reason, therefore, that feelings of not caring can also occur spontaneously. If this is the case, a question which is raised is should nurses feel free to follow spontaneous emotions to care or not care as did both Ruby and Ella. The conundrum is if we accept that a nurse ought to be free to like or dislike a patient, this could lead to discrimination against a patient because of this choice. The key question is what should nurses do if this situation arises? Previously, I discussed Noddings’ (1984) study of ethical care where she suggested that one’s vision of the ideal self and the actual self meet and struggle in an effort to remain in the caring relation. Noddings (1984) suggested that, although we are free to reject the impulse to care, by doing so, she offered, “I enslave myself to a particularly unhappy task when I make this choice” (p. 51) or, as Stockdale (2000) suggested, by choosing not to care we leave ourselves vulnerable to burnout and feelings of personal failure. What is evident in the stories of these participants is that each was on an individual journey of discovery of what it was
like to care for prisoner-patients. For some, the journey was frightening and confusing, while for others it was more familiar and somewhat comfortable.

The participants acknowledged that at times their beliefs and abilities were compromised. As Smith and Smith (2008) asserted, it is important to have the “ability to extract ourselves from situations that compromise our integrity and beliefs” (p. 53). Belinda demonstrated this when she said that she believed you needed to own your feelings in a caring situation and if you felt compromised then you should feel able to step away from the relationship. She placed care of herself above care of her patients. Hoagland (1990) asserted that at times withdrawal from a relationship is necessary to preserve an ethical ideal. As she explained:

I must be able to assess any relationship for abuse/oppression and withdraw if I find it to be so. I am not full of guilt, I feel none. I have grown, I have learned something. I understand my part in the relationship. I separate. I will not be there again. Far from diminishing my ethical self, I am enhancing it. (p. 111).

This is a truly challenging concept because if your beliefs are compromised, you may need to extricate yourself from the situation. But in doing so what does that suggest about your nursing ideals? Within health care organisations it is said someone has to care. What would happen to care if everyone wanted to extract themselves from a particular caring situation, in doing so placed the burden of care on remaining colleagues? Andrew considered that at times he was left as the remaining nurse to accept the challenge of caring in circumstances where no one else wanted to and this expectation was stressful for him. However, the ideal that someone has to care is frequently not conceptually bound; that is, literature intimates that caring should be equally applied in all situations and circumstances, an imperative that is challenged by these study findings. As Gadamer would remind us it is not possible to be entirely non-judgemental as we bring to any situation our prejudices or pre-understandings. Hoagland reinforced how hard it is to be non-judgmental when she suggested that even not to judge is to judge. This is the crux of the issue for the registered nurse participants who cared for prisoner-patients. If our personal reaction to a patient is one of judgement, fear, distrust or even intense dislike can we respond in a professional manner by withdrawing elements of care? Or do we engage in a form of ethical care, drawing on all our emotional resources? Warelow (1996) suggested the care imperative needs to be reviewed, among other things, in context and cognisant of individual circumstances. I also concur with those who suggest that the ideal of nursing care
Discussion

does not always encapsulate the day-to-day realities of the experience (Stockdale & Warelow, 2000) and fails to capture the emotional complexities involved (A. Smith, 2009).

The woes of knowing

Aspects of caring for prisoner-patients that participants reacted to were the patients status as prisoner, knowledge of their crime and at times even imagining of what that crime might be. These factors compromised the participants’ ability to care. Of significance was the different impact certain crimes had on the participants. For example, many female participants found it particularly difficult to overlook crimes against women. Sociologist Diana Kendall (2008) suggested that women tend to be more fearful of crime, especially crime directed towards them such as rape. For the mothers in the participant group, crimes against children held a special significance; and Andrew found terrorism particularly difficult to deal with.

There was certainly a hierarchy of crime, considered by the participants; crime for financial gain, such as tax evasion or armed robbery was less likely to create feelings of angst among the participants than crimes against people. Reactions to crime were reinforced by the guards who on occasion broached the subject of the prisoner-patient’s crime. Beth for example, expressed that guards tried to influence nurses’ behaviour by telling them what crime the prisoner-patient committed. This finding is consistent with Holmes and Federman (2003) who identified that contact between nurses and prison guards can impact the nurses perception of a patient, sometimes amplifying preconceived ideas.

Valuing experience

What made a difference to expressed feelings of judgement and anxiety, many participants asserted, was their overall experience with prisoner-patients. Even some of the more junior participants believed that during the 6–12 month gap between interviews they gained significant confidence with the care of prisoner-patients. Experience with caring for prisoner-patients is one element that appeared to alter participant’s values and attitudes and this aspect is well documented in literature.

To explore this concept further I focus on the work of Bourdieu (1984), a French sociologist. Bourdieu believed individuals are endowed with different experiences depending on their social position. All that we have experienced, culture, religion,
social status, influence the person we are and how we interact with others. He called this experience *capital*, which he believed was any resource that is effective in bringing success in a particular social setting. Economic wealth, education, social networks, life experiences such as travel all contribute to an individual’s capital. In addition to the notion of capital, Bourdieu discussed another social concept, *habitus*. Habitus is a person’s beliefs and includes acquired dispositions involving things such as lifestyle, dress, body language and personal taste. The significance of Bourdieu’s concepts in a nursing culture have been explored by some authors (Clabo, 2008; H. Cooke & Philpin, 2008) who assert that the social makeup of an individual nurse influences their practice. Gadamer (2004) offered we are the total of all our life experiences. Putting this idea into perspective, the participants’ capital and habitus, and their social influences shaped their belief systems and the way they approached prisoner-patients. As Carlsson (2009) offered, we bring our personal and professional baggage to the practice context. It was evident that life experience influenced the participants of this study and impacted on their care. Beth, for example, had an encounter as a young adult with a man who was later convicted of child abuse; and she expressed that this life experience affected her profoundly.

Generally, experience influenced care in a positive sense. Beth said she previously treated prisoners differently but “now I just treat them like any other patient”, Tracey also agreed that experience had enabled her to do a better job. Arguably with maturity, we become comfortable with who we are, and more accepting of those who are different from us (Mannahan, 1989) and this is part of the personal journey we all undertake in life. Pask (1997) suggested beliefs are developed as a result of personal experience. She also suggested that this was an immediate process when she said:

> Although we cannot will to believe, we can seek to avail ourselves of that evidence necessary to the development of our beliefs, and avoid believing only what is easy to believe. This is important, since we are all predisposed through experience to believe some things more than others (Pask, 1997, p. 208).

When faced with difficult situations while caring for prisoner-patients the participants focused on the challenges inherent in the experience and at times made conscious decisions to redirect their attention and change their thought processes to a more positive light. Doing so involved an acknowledgement that there was something within the experience worth improving. While some
participants believed they had nothing in their practice they wanted to change, others (Andrew, Beth, Belinda) actively sought to improve their care of prisoner-patients. In the midst of constant interpersonal conflict, listening to their internal voice had the potential to focus the participant on constructive ways of dealing with challenging situations. Alavi and Caltoni (1995) suggested the core of the nursing universe is the individual nurse and the beliefs that they hold about themselves and nursing. These individual beliefs are paramount to the nurse–patient relationship.

Roach (2002) asserted caring is expressed in virtuous action and is acquired over time. There was evidence in the participants’ dialogue that experience was clearly of benefit to their ability to participate in the care of prisoner-patients; however, there was also evidence that with more experience participants became increasingly cynical and detached. The process by which a nurse gains experience and expertise is described well by Benner (1984) in her theory of knowledge development ‘novice to expert’. In order to progress toward expertise, beginning and competent nurses need rules and guidance to follow as they develop their analytical skills. It is suggested by Day (2009) that those who are not expert practitioners needed help to determine if their emotional engagement and responses to patients are right or if they somehow got it wrong. As a novice, a junior nurse is often unable to formulate their own judgement about a complex ethical situation such as the nursing care of prisoner-patients. For example, junior participants such as Ryan and Ruby, who did not have a wealth of experience, relied heavily on judgements rendered by others, such as the medical staff and the prisoner guards as a barometer of the prisoner-patients worth. Even Sarah, who was an experienced nurse who had minimal exposure to the care of prisoner-patients, displayed evidence of unreflective thought processes.

As previously discussed, however, the practice of relying on others to form understanding is fraught with difficulties as it can lead to the provision of discriminatory care (Holmes, 2003). Benner suggests that lack of critical reflection is a characteristic of novice and beginner nurses, who are not able to demonstrate evidence of deep thought, which is applicable to the experience of the participants of this study who cared for prisoner-patients. However, several nurse participants in this study who had considerable experience of caring for prisoner-patients asserted they made conscious choices not to engage in considered thinking. As they suggested, unless they placed some distance between their emotions and the prisoner-patient experience they would be negatively affected, or broken. Despite
this assertion, there remained clear evidence of critical thought, most were able to articulate how profoundly interactions they had with prisoner-patients affected them.

Stan van Hooft (1987) wrote about the benefits of clinical experience, suggesting that time spent with others, and a willingness to discuss previous experiences while placing previous judgements under review, enabled an experienced nurse to develop ethical sensitivity to patients. Developing ethical sensitivity enables professionals to recognise, interpret and respond appropriately to the concerns of patients (Weaver, Morse, & Mitcham, 2008). In the participants’ dialogue there was evidence that they discussed their experiences with each other, but not in any structured way or formal sense. The discussion was more storytelling and myth like in its content. However, in the right circumstances there is a definite benefit to working within an environment that encourages constructive reflection and discussion.

The association between confidence and experience was an interesting one. Some participants appeared confident even if they did not have experience or skills to reinforce this confidence. One striking example of this was the dialogue of Kara, who considered it to be imperative to be confident and in control. Dellasega, Gabbay, Durdock and Martinez-King (2009) discussed the term ‘imposter phenomenon’ which described, a phenomenon whereby nurses secretly feared others would discover they were not as competent as they appeared, and felt a need to present themselves as an expert no matter what. This was true of some participants, although others were very open about their perceived failings with their care of prisoner-patients.

I have touched on the idea that the participants of this study looked to more experienced colleagues for cues as to how to behave. Role-modelling and socialisation are significant elements of a nurse’s development and experience. The care a nurse provides is developed by socialisation, as Mackintosh (1999) asserted:

> Socialisation processes have a fundamental impact on the nature of care, for whether care is regarded as an innate human trait, a moral or spiritual imperative or part of a reciprocal relationship, and regardless of its physical or expressive nature, the care which nurses provide is shaped by the socialisation of nurses experience (p. 324).
Role-modelling is a process where values and attitudes are learned, not just skills and knowledge (Goldenberg & Iwasiw, 1993). The participants looked to other nurses to develop a sense of how to care for prisoner-patients and manage their emotions. Prudence saw a colleague laughing and joking with a prisoner-patient; until then she had not considered the possibility of being that relaxed in her approach with prisoner-patients. Consequently, she became far more comfortable with her interactions. Beth thought about how she interacted with prisoner-patients, and what was important to her. For example, she strove not to know the patient’s crime, and sought to influence younger staff so they would not elicit this information either. Observing others provides cues of behaviours participants did not want to emulate. Ryan witnessed practices which he chose not to replicate in his care of prisoner-patients, which is an important point because as Mackintosh (1999) suggested, nurses can be taught not to care through socialisation and role-modelling.

Real and ideal expressions of care

Authors have contributed to the discourse on caring as an ideal that is fundamental to the nursing process (Mackintosh, 1999; Roach, 2002; J. Watson, 1988). While worthy, this expectation of caring rarely acknowledges that nurses as humans are flawed, make judgements, and need to consider the complexities of the care dynamic. The participants of this study found that the care of prisoner-patients did not necessarily evoke a spontaneous desire to be near the patient and to share in their world view. In some situations this caused the participants distress as their desire was to be able to deliver quality nursing care to prisoner-patients. Sentiments expressed by Beth, such as ‘you’ve got to care’ or by Ruby ‘they all deserve the best care we can give them’ are examples. The participants sought to reconcile their ideals to determine the type of care they would deliver. For some of the participants the desire to care seemed lost. For instance, Sarah seemingly expressed her ideals of caring in a perverse way when she claimed that if prisoner-patients were reasonable to her in terms of behaving themselves and being polite they would get the same back from her. However, if prisoner-patients swore at her, were nasty, rude or non-compliant she would treat them with contempt. Similar thoughts were expressed by Ella who said she had a patient that she was not empathetic towards and was not willing to stretch beyond her means. These views contradict sharply with those of Belinda who was moved to compassion when she expressed that prisoner-patients are really disempowered and totally at the mercy
of the system. She reflected “you know, a mother loved that child” and her dialogue revealed that these ideals enabled her to provide dignified care.

The dialogue of these participants is replete with suggestions that contextual interferences such as having patients shackled to the bed; having guards present; meeting patients who had committed violent crimes; or even encountering patients who were covered in tattoos and rough around the edges deterred their ability to suspend judgements. The participants identified many issues surrounding analgesia delivery to prisoner-patients and whether the patients request for pain relief was a real request to relieve discomfort – seemingly the very real need for analgesia post-operatively was often overlooked in the participants dialogue – or a play to get drugs which Peternelj-Taylor (2004) describes as secondary gain. As identified in the literature review there is a significant incidence of intravenous drug use within the prison population and nurses are aware of this. In situations whereby a patient has a tolerance to narcotic medication, either through abuse or a chronic condition, analgesia can be difficult to achieve in the post-operative environment (Layzell, 2008). Further, doctors can be reluctant to prescribe narcotics (Tamayo-Sarver, et al., 2003). Interestingly, participants’ of this study (Rachael and Ella) expressed that they did in effect suspend judgements regarding analgesia administration when they gave in and gave the prisoner-patients the analgesia they requested as it was easier than thinking it through. Underlying the participant’s discussion was a belief that prisoner-patients are manipulative.

Bowers (2003) offered the opinion that the only route open for prisoners to gain respect from others are manipulative deeds that involve displays of strength, nerve, skill and risk taking or, as Willmott (1997) summarised:

> It will sometimes be difficult for the nurse to know whether or not he/she is being manipulated. It would be naïve not to acknowledge that manipulation by the prisoner does occur. Prison is boring. Any diversion such as pitting one’s wit against staff has the reward of breaking the monotony. The psychological game of obtaining medication on a false pretence is popular with prisoners (p. 334).

For health care workers, the fear of being manipulated is very real. There is a possibility that one can be made to look foolish, participating in an action that has some secondary gain for the prisoner such as. drugs, escape, diversion or entertainment (Peternelj-Taylor, 2004). Evident in the discussion of Ruby was a point that the guards made her feel foolish when she was undertaking a pain
assessment, which aroused feelings of anger and doubt regarding her nursing competence. Bowers (2003) highlighted that being subjected to manipulative behaviour naturally aroused strong feelings in the victim, typically anger, fear, guilt, shame and disappointment which was certainly the case for Ruby.

Some participants believed that they could astutely assess the prisoner-patients analgesia requirements, both the amount and the frequency of analgesia they requested and whether it was warranted. For example, Andrew believed he had experience that enabled him to differentiate between drug-seeking behaviour and genuine pain. And Sarah asserted that she was fully competent to give prisoner-patients analgesia, although she did so without compassion. Kara believed in the patients’ right to analgesia, and stated she treated the prisoner-patients pain effectively. Tracey, and I, questioned our administration of analgesia, because of conflicting thoughts about the patient’s worth, and the pain they had caused others, and although analgesia was not consciously restricted there were judgements made. Andrew for example, at some point decided to withhold analgesia when his assessment was that the patient was pain free and I was acutely aware of how easy it would be to cross the line and become unkind and punitive. The pain management of prisoner-patients highlights the conflict the participants experienced between their ideals of nursing care and the reality of their experiences.

The impact of spirituality on the nurse–prisoner-patient dynamic

In a broad sense spirituality is that which connects us and gives us a sense of meaning (Wong, Lee, & Lee, 2008). To some it is a relationship with God or the divine, and centers around the practices and traditions found in many religions. However, formal religious affiliations are not a pre-requisite of spirituality as an individual who is unaffiliated with traditional religion can be spiritual. Spirituality, as suggested by Wong et al. (2008) can also be found in a connection with nature, music, art or scientific reasoning.

When discussing the impact of spirituality on practice, and echoing Gadamer’s notion of prejudice, Wright (2010) has offered “we are not psycho-spiritual sealed boxes – we are sieves. We leak in obvious and not so obvious ways” (p. 27). What was identified by Tracey and to a lesser extent Rachael was the benefit they believed they had when caring for prisoner patients because of their own spirituality, which seeped into all areas of their practice. Gully (2005) argued that
an awareness of spirituality has a two-fold benefit. On an individual level it creates a sense of wellbeing and contentment that she referred to as nourishing the soul and it enables the individual to develop better caring relationships. In practice both Tracey and Rachael seemed better equipped to move beyond judgement of prisoner-patients than many of the other participants. They were both able to meet prisoner-patients as people and accept their needs in a holistic sense. McFarlane (1981) believed spirituality better equipped nurses to deal with the difficult aspects of care. Ekedahl (2009) also found in a study of palliative care nurses that religiosity (strong religious beliefs) was a coping resource for these nurses. Tracey suggested, “I don’t know how other people manage if they don’t have their faith to fall back on”. Rachael tried to live her life God’s way with compassion and dignity. What was suggested in the context of this study was that the spirituality of some participants aided their ability to care for prisoner-patients.

Caring for ourselves

Nurses caring for each other and for themselves is essential to quality health outcomes (Chow & Grant Kalischuk, 2008; Duffy, 2009; Jackson, 2004a; J. Watson, 2008). It is important for nurses to care for themselves and their colleagues to enable them to feel comfortable and be able to care for others. Care for self involves fundaments such as physical care, diet exercise and rest (Iacono, 2010), and emotional care through self-nurturing behaviours (Chow & Grant Kalischuk, 2008; Pantaleo, 1977). The term self-nurturance focuses on mind, body and spirit and refers to self-chosen thoughts, feelings or behaviours that foster a healthy life (Nemenack, 2007). This is an essential element in addressing a gulf between the hard realities of nurses’ experience as evident through the dialogue of the participants and the pursuit of their ideals, facilitating them to become all that they can be. Nemenack (2007) conducted a study which explored a group of nurses self-care behaviours in the United States of America and concluded there was a significant positive correlation between life satisfaction, self-nurturance and career satisfaction.

Another element of nurses caring for themselves is to be attentive to each other’s needs outside of the work environment (Curzer, 1993). Several participants spoke of bringing work home; Kara spoke of feeling haunted by experiences at work and Andrew said he could not stop thinking about some of his experiences. Conversely, problems from home can be brought to work and impact on a nurses’ ability to
Discussion

care, as previously discussed. The ability to debrief in a casual social setting with colleagues is invaluable as is the support of family and friends. Interestingly, neither of these aspects was discussed by the participants in the context of this study. In Penelope Cash’s (2000) work on collegiality in nursing she discussed the importance of teamwork and a sense of belonging. This included the value of listening to yourself and your emotions as a significant element of caring.

A report of a paper given by Carolyn Simmons Carlsson (2009), who spoke at a conference of New Zealand occupational therapists, expressed similar sentiments to those of Cash and drew an analogy between professional practice and the koru (the New Zealand fern); “for me, the action of the unfurling koru encapsulates how we as individuals unfurl throughout our professional journeys” (p. 28). She suggested that, to care for yourself, to grow and unfurl like the fern, you need to “know thyself, own thyself and grow thyself” (p. 28). This interesting conceptualisation is easily transferable to a discussion on nurses caring for themselves, and there is some evidence through the participants’ dialogue that they were aware they were unfurling.

“Know thyself” is to understand one’s own cultural and social underpinnings, experience, background and attitudes including one’s strengths and weaknesses. Carlsson believed we needed to take time to reflect on who we are and whether we act in accordance with our values and beliefs. Beth did this during the interview process and decided that she was not acting in a way that upheld her beliefs and so she adjusted her practice accordingly. “Own thyself” involves owning your choices, decisions and emotions. Emotional intelligence is the ability to appraise and reflect on one’s emotions (Bellack, 1999; Fuimano, 2004) and to grow and learn how to channel one’s emotions in positive and respectful ways. Belinda believed that nurses needed to take responsibility for their emotions when caring for prisoner-patients and to value what is experienced on an emotional level as significant. In grow thyself Carlsson behoves us to take responsibility to nourish our competency and wellbeing by learning and growing as a practitioner. Thus it can be seen that by being responsible for themselves, their choices and their education, nurses can strive to care for themselves. The participants of this study did not discuss self-nurturing processes and I suggest that further research is warranted to more deeply explore the self-care practices of nurses who work within an acute care environment and provide care for prisoner patients. Caring for
oneself takes thoughtful introspection and commitment (Iacono, 2010) such as seen through the process of reflection.

**Considering reflection**

Reflection is the process of deeply considering our behaviours and feelings, asking ourselves if we have learnt anything or could have done anything better. Reflection not only aids in the development of critical thinking skills but it also acknowledges the value of spirituality and aids in self-nurturing practices. It is an ongoing process towards having a right relationship with ourselves and achieving harmony and balance of mind, body and spirit (Becker Hentz & Steen Lauterbach, 2005). The terms reflectivity or reflexivity, are both used interchangeably within the literature. They are generally taken to mean a tool that encourages self-reflection and a critical appraisal of thought with the goal of developing understanding. I have taken these ideas of reflexivity and reflectivity and interpreted them in the same manner as Allen (2004) who asserted that reflexivity is a narrative of the research environment whereas reflectivity is of oneself.

Research has shown that reflective practice offers nurses a stronger sense of personal and professional worth (B. Taylor, 2001) and like spirituality it draws the nurse back to their humanness and enables them to consider some of the bigger questions in life and in nursing relationships and behaviours. Transformation and growth are key aspects of reflection (Becker Hentz & Steen Lauterbach, 2005) and personally I found the process of reflection was fostered throughout this study by the maintenance of a researcher journal. I was able to clearly identify my thoughts and reflect on them critically. Gadamer asserted that understanding was historical and that it changes over time. Reflection is developing awareness as to how your understanding is changing over time. The journal made this process concrete and visible.

When this study was in its early conceptual stages, I noticed that my colleagues considered they cared for prisoner-patients the same as any other patient. Although the participants did not speak directly of reflection it was very evident in their practice where they often deeply considered their care and their humanness. Their reflection was as simple as giving voice to something – through verbalising their concerns participants acknowledged them as significant because they resonated with them in some way, a process which occurred several times throughout the interviews. For example, Ella offered that she never touched
prisoner-patients and realised that, prior to saying it out loud, she had not thought about that being true, and Rachael admitted that, despite her best intentions she did not actually treat prisoners the same way as other patients. The process of reflection improved the awareness of the participants care of prisoner-patients. Critical reflection can assist to strengthen one’s knowing of the self, one’s thinking and one’s deep understanding of one’s practice (Simmons Carlsson, 2009). It also improves our emotional intelligence (Vitello-Cicciu, 2003). In addition to reflection enhancing self-awareness Becker Hentz (2005) suggests that reflection enhances a nurses ability to be aware of the other, the patient. In this way the process of reflection contributes to the caring dynamic. Through my engagement in this study I more fully appreciate that the participants and I can more intentionally use the reflective process to transform and grow in our practice and this is one recommendation that I will make in our unit.

The experience of burnout in this care setting

The participants of this study did not identify that they experienced burnout directly but on reflection they offered many tacit suggestions that they experienced some of its effects. Two of the key symptoms of burnout as offered by Demerouti, Bakker, Nachreiner and Schaufeli (2000) are emotional exhaustion and depersonalisation. Zapf (2001) examined burnout in nurses and suggested burnout can be seen as a growing inability to adequately manage emotions when interacting with patients. The participants often considered that their ability to manage emotions with prisoner-patients changed over time and in two opposing ways. What became more manageable for the participants was their ability to distance themselves from the caring interface to reduce the emotionally draining aspects of the experience. An example of this was Ruby who offered that with time prisoner-patients became easier to care for as she was not as emotionally involved with them as she had been previously. Andrew also withdrew emotionally from prisoner-patients as he struggled to remain non-judgemental; his care appeared to lack warmth at times. This behaviour of reduced emotional involvement has the possibility of precipitating the depersonalization identified by Demerouti et al. and resulting in burnout. Alternatively some participants reduced their anxiety and engaged with prisoner-patients in a genuine sense; examples of this behaviour were offered by Beth, Rachael and Tracey. The possibility exists that these participants could be at risk of emotional exhaustion. Both responses can leave the participant open to risks of burnout, either through emotional exhaustion or depersonalisation. The experience
of caring for prisoner-patients generates significant discussion and food for thought. The balance between giving and caring for the patient – while caring for ourselves and others around us – is difficult to strike. It is a conundrum that as yet has not been given enough attention within the literature in particular when we consider complex care situations.

**Chapter summary**

In literature what is not fully articulated is the gamut of responses that are possible and that create challenging care situations. While some acknowledged that registered nurses may not like their patients, perhaps further exploration is required to unveil the possible pervasiveness of this phenomenon. Individual nurses are responsible for deciding how they will enact their caring practice taking into account their life experience, maturity, clinical skills and code of practice, without sacrificing prisoner-patient wellbeing. As Olsen (2001) eloquently suggested empathetic maturity is seen when an individual is able to differentiate their assessment of culpability from their emotional response. This assessment, Olsen argued does not excuse a patient’s choices, nor does it require a nurse to abandon their own values. Rather it requires a shift in attention away from blame towards understanding the complexity of the situation. The registered nurse participants of this study through their dialogue revealed that they were all on a personal journey where they had a desire to care for prisoner-patients but were at different stages of being able to act on that desire.

In this chapter I reflected on the methodological choices that I chose to conceptualise this study as well as the study design which used interviews, observation and journalling. On every level I am confident that the choices I made were wise, while being fully aware that there were elements that could have been improved.

The study findings were also reflected on in this discussion chapter, undoubtedly the experience of caring for prisoner-patients in an acute environment was one which was challenging for the participants. In this chapter I discussed the way the participants met these challenges, utilising coping techniques such as distance, both physically and emotionally, listening to their inner voice and the value of experience. I also offered some suggestions as to how these challenges may be best addressed through, among other things, self-nurturance, reflective practice and spirituality.
Chapter Seven:

Conclusion
In this thesis I used a Gadamerian approach to knowledge construction to distil the essence of caring in the complex and challenging situation of registered nurse care for prisoner-patients. When I returned to my early prejudices of the experience, it can be seen that my understanding of this phenomenon was limited and clearly not reflective of all that the participants’ shared about this experience. Some of what I have learned about the experience of care is reflected in the literature, but much of what the participants expressed was unique to their circumstances and perhaps overlooked in the current discourse on how registered nurses care.

Prior to their immersion in the study the participants considered that their care of prisoner-patients was no different from their care of other patients; however, over time and with reflection they realised there were significant differences between the way they related to prisoner-patients when compared with other general patients. The physical care they gave was subtly different, performed from a distance, often with judgement, and was even restricted at times. What was altered in a more substantial sense, was their attitudes about the imperative to care, which they restricted at best or withheld altogether. The participants experienced a mixture of distance and intimacy with prisoner-patients, and often found balancing these polarised positions difficult to enact. Many emotions percolated with the participants as they identified their care of prisoner-patients was emotionally draining and fell far from their ideal of what care should be.

The findings of this study offer a view that concretises the complexity of caring for patients in potentially challenging and real situations. The findings are grounded in a rich description of the meanings, experiences and challenges faced by nurses when caring for prisoner-patients. Tacitly, I suggest that the participants of this study struggled at times to meet their own emotional needs, let alone their patients’ needs. The participants were all good people, good nurses who came to work each day to do the best job they could. However, the culmination of the personal and environmental issues that were revealed through their frank dialogue took their toll and severely restricted enactment of a satisfactory nurse–patient relationship. Essentially we are all flawed human beings doing the best job we can in a situation which is not easy. The care of prisoner-patients is difficult and my engagement in this study has made me wary of idealized nursing theory which I suggest could set nurses up to fail if they are unable to meet ideal expectations placed on them. While nursing ideals are valuable, and recognize inspirational goals they need to
be cognizant of our humanity and failings and recognise our desire to do more and do better.

Caring can take many forms and in different circumstances the relationship between a nurse and patient forms easily and naturally. With prisoner-patients this might be true much of the time. However, this is not always the case if for whatever reason the nurse struggles to enact a caring relationship. Consider this example, one evening recently I was watching the evening news and a story was Headlined about a man who poured petrol over his girlfriend and burnt her alive. He did this in public, near families and children. Bystanders, who tried to help, spoke of their nightmares and hearing the woman scream as she realised what was happening to her. The next day while I was at work a prisoner arrived for treatment to burns on his hands. I didn’t need anyone to tell me who he was, no one said a thing. And yet everyone knew who he was and what he’d done. I entered that caring dynamic with the best of intentions, with a sound resolve to rise above my personal feelings and to be non-judgemental. Then something happened: it could have been the smallest thing from a smile to a profanity. For me it was the way this man spoke to me and I felt myself shut down. At the time it did not feel like anything I could control. I became robotic and began just going through the motions of care. I think not enough is understood about the complexity of this dynamic.

In emergency medical situations, it is drilled into nurses to be aware of danger to themselves, and to ensure safety above all else. We learn that we are no help to patients if we become injured. Emotionally however, this safety to self mandate is not realised to its fullest potential when caring for prisoner-patients. We need to fully consider the implications of the expectation to care no matter what, and the impact this may have on the nurse’s sense of wellbeing.

As a consequence of my involvement in this study I have developed a greater appreciation of the complexities of the nursing role. Despite years of research and reflection on the dynamic of nurses caring for prisoner-patients or indeed caring in any complex environment, and despite my desire to do my job from a position of empathy and understanding, I do not find it something which comes with the ease and integrity I would strive for. At the beginning of this journey I believed that if I tried harder I could be better. Through this process I have discovered the value experiences in life and how they make us grow and evolve, but I also have an increased sense of value for my colleagues and the support gained from others.
One suggestion I make is for nurses to be regularly provided with opportunities to engage in frank discussion about the experience of caring for prisoner-patients and to verbalise how they feel about this relationship. It is not only imperative to listen to and to acknowledge nurses’ experience of their professional practice; it is also imperative to support nurses to achieve their goals. What is needed, I suggest, is the creation of a moral climate that sustains nurses as they attempt to shape their behaviour and to develop emotions as they respond to demands that are placed on them within today’s world of health care, which resonates with the work of Pask (2001). The findings of this study support Mackintosh (1999), who argued that the status of care in nursing should be seriously reconsidered as it is naive and misguided.

While I have taken care in this study not to imply that the findings of this study can be generalised to all nurses, or even all theatre nurses, I believe that the findings have the potential to shape and inform nursing practice. They highlight the complexity of the experience of care and remind us how vulnerable we all are in our professional capacity. The impact of the findings of this thesis for nursing practice renews an emphasis on caring for ourselves and supporting each other. In this way nurses will be in a better position to care for others. In the first instance I believe an orientation program for new staff should be established to provide education on some of the broader issues of caring for patients who are prisoners. Education and induction needs to be grounded in the reality of the demographic of patients; break down stereotypes, highlight the custody versus care dilemma, and also the social factors that contribute to crime so the nurses are informed of the bigger social and cultural picture that influences crime. I see the development of an education program as a contribution I can make to the hospital to thank them for enabling the study to be undertaken.

In line with this suggestion, within the study hospital there is currently a mentorship process for new staff. However, this relationship could be extended to include an emphasis on providing social support. The situations that registered nurses who care for prisoner-patients are placed in is as challenging as those faced by nurses who work in a critical care environment. Management would do well to acknowledge that the care of prisoner-patients is at times quite demanding. That the nurses who participated in this study need ongoing support and an opportunity to debrief about their experiences is self-evident. I recommend that the participants of this study together with colleagues who did not participate establish a regular
support group where they can talk about care issues relating to prisoner-patients in a safe and supportive environment. The hospital already provides counselling services free of charge to hospital employees and it would be reasonable to suggest that after particularly challenging situations we enlist the professional help. This is another recommendation that I will take to management.

I also assert that it is reasonable to suggest we should reinforce the value of caring for ourselves, as well as for our patients in a more general sense. The perioperative environment is a highly technical nursing context with many acute care demands but general education emphasizing holistic care could be beneficial. It is also sensible to suggest that all nurses examine their belief structure and identify whether they align with a philosophy of giving. The participants and their colleagues already have well established social networks and these should be encouraged.

Further studies are needed that highlight the complexities of care in the real world as nurses experience it, which is often far removed from idealised versions presented in the nursing literature. By understanding more about what makes care easy in some circumstances and not others we have the potential to improve both the patients and the nurses experience.

In keeping with Gadamerian ideas on understanding the findings of this study are unique to the journey experienced by the participants and myself. The methodology and methods undertaken to explore the experience of registered nurses caring for prisoner-patients make a significant contribution to understanding the complex phenomenon of caring for prisoner-patients. If I was to repeat the study I would undoubtedly do it differently, as we all change and grow over time, moving forward to expand our horizons. However, I am grateful that the choices I made with regard to the study methodology and method enabled the voices of the nurse participants to be heard.

In a sense the participants and I were on a journey together to identify what caring for prisoner-patients was like. Together we fine-tuned our understandings and our world view. As Gadamer (2004) suggested, we are the whole of our lived experiences, and we bring all that we have experienced to living our lives and in this instance to the interface with prisoner-patients. The impetus for this study which I revealed earlier, that of meeting a man in the street too anxious about the
nurses judging his alcohol addiction and withholding care made me pause and think about responses to certain patients, as does a history of knowing someone close to us who has experienced trauma at the hands of another. These things have an impact on our ability and desire to care for others. Many of our thoughts are transformed even as we verbalise them, yet others remain fairly constant throughout our lifetime. Regardless, life and experience are a journey to become all that we can be.
References


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Appendixes

Appendix A: Ethics approval hospital & university

Monday, 11 September 2006

Ms R Crampton

Attention: Dr D S Turner

Dear Ms Crampton,

Protocol No: HREC-A 091/06

'Exploring experiences of registered nurses caring for prisoners in an acute environment.'

Ms R Crampton Dr D S Turner Dr H Cox Dr M Duke

The Professional Secretariat of Human Research Ethics Committee-A (HREC-A) has agreed that your latest correspondence dated Monday 21 August 2006, has satisfied the conditions imposed and granted full approval for this project to be undertaken at [redacted].

HREC-A is constituted and operates in accordance with the NHMRC National Statement on Ethical Conduct in Research Involving Humans 1999 (including supplementary note 7 dated November 1992).

HREC-A has a policy of granting approval for four years. Ethical approval is valid for four years from the date of this letter. Approval may be renewed at the end of this period by resubmission to HREC-A.

Approval is subject to:

1. immediate notification to HREC-A and sponsor of any serious adverse effects on participants;
2. immediate notification of any unforeseen events that may affect the continuing ethical acceptability of the project;
3. notification and reasons for ceasing the project prior to its expected date of completion;
4. the completion of an annual report on progress of the project;
5. HREC-A approval of any proposed modification to the project; and
6. the submission of a final report and papers published on completion of project.
MEMORANDUM

TO: Ms Ruth Crampton
Nursing
Melbourne

FROM: Secretary, Deakin University Human Research Ethics Committee (DU-HREC)

DATE: 18 December 2006

SUBJECT: PROJECT: EC 293-2006 (Please quote this project number in future communication.)

EXPLORING EXPERIENCES OF REGISTERED NURSES CARING FOR PRISONERS IN A PERIOPERATIVE ENVIRONMENT

Interim approval for this project was ratified by DU-HREC at meeting 8/06 on 13 December 2006.

APPROVAL HAS BEEN GIVEN FOR RUTH CRAMPTON, UNDER THE SUPERVISION OF DR DE SALES TURNER, SCHOOL OF NURSING, TO UNDERTAKE THIS PROJECT FOR A PERIOD OF 3 YEARS FROM 9 SEPTEMBER 2006.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Secretary immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HREC's.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

Vicki Xafis
Executive Officer, Human Research Ethics
(03) 9251 7123
Appendices

Appendix B: Poster inviting participation

Invitation to participate in a research project

‘Exploring experiences of caring for prisoners in an acute environment’

Your participation will require two conversational interviews, about one hour each. These interviews will be at a time and place convenient to you but in your own time.

It will also involve being observed clinically on several occasions by Ruth Crampton, while you are looking after a prisoner-patient in PACU. These observations will occur during your normal working day.

I am not looking for right or wrong answers but rather I am interested in what the experience of looking after a prisoner is like. Because St. Vincent's Hospital offers surgical services to prisoners you are in an ideal position to discuss this area.

The information generated from this research will be part of Ruth Crampton’s PhD thesis

If you are interested in participating please phone ..................... on ............... or email..............

For further information and consent forms
Appendix C: Participant information

Health/Deakin University

Participant Information and Consent Form
Version 2 Dated 19.08.06

Protocol no. 091/06

Name of Participant

Name of investigators: Ruth Crampton
De Sales Turner
Helen Cox
Maxine Duke

Full Project Title: Exploring experiences of registered nurses caring for prisoners in a perioperative environment

This Participant Information and Consent Form is 7 pages long. Please make sure you have all the pages.

1. Your Consent

This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

The purpose of this project is to explore the experience of nurses caring for patients who are prisoners in a general setting.

A total of 15 people will participate in this project.

Previous experience has shown that caring for prisoners may present many different challenges from caring for other patients. They have specific health concerns and physical restrictions such as handcuffs and the presence of guards which makes some procedures difficult to perform and compromises privacy.
There have been several studies examining prison nurses and their approach to caring for prisoners, but very little has been written about what it is like to care for prisoners in a general setting. The current study aims to explore with registered nurses what the experience of caring for prisoners in the acute care setting is like.

You are invited to participate in this research project because your role in the recovery room, either directly or indirectly caring for prisoners as patients. Your contribution could provide important information about how to care for this select group of patients.

The results of the research will be used to help researcher Ruth Crampton obtain a Doctor of Philosophy degree at Deakin University. The research could also be presented at conferences or submitted for publication in national or international nurses journals.

3. Research Participants Rights

If you have any questions about your rights as a research participant, contact Jill Hambling, Executive Officer research at xxxx Health on Telephone xxxx-3930 or the Secretary, Ethics Committee, Research Services Division, Deakin University, 221 Burwood Highway, Burwood, Victoria. Telephone xxxx-7123. Please note that this study is a combined project between Deakin University and xxxx Health any question regarding participant rights notified to one organisation will also be forwarded to the alternate ethics committee.

4. Procedures

Participation in this project involves several steps; an initial interview (approximately one hour duration), being observed (3-5 occasions) during routine work and a final exit interview six months after the initial one.

Examples of questions that will be raised at your interviews are:

- What are your thoughts on caring for patients generally?
- What are your thoughts on caring for prisoners specifically?
- Have you ever found caring for patients difficult and if so could you provide some examples?
- Have you ever found caring for prisoners difficult and if so could you provide some examples?
- Thinking of caring for prisoners is there anything which might get in the way of caring for them in the way you might like?
- Has there ever been a situation when you were caring for a patient and you lost your will or desire to care?

As you can see, there are no right or wrong answers to these questions. They are raised so that the researcher can develop an appreciation of what it is like to care for prisoners within an acute environment, from the unique perspective of
the registered nurses concerned.
The interview will be audio taped and transcribed verbatim. Once transcribed
the audiotapes will be destroyed. A summary of the transcription will be given to
you prior to the second interview to remind you of what was discussed in the
first meeting.

On at least three occasions but no more than five, Ruth Crampton will observe
you providing nursing care to a prisoner in the recovery area. The purpose of
this observation is to gain a deeper understanding of issues that you raised in
your interview.

5. Possible Benefits
To nursing generally, possible benefits include a better understanding of the
scope of nursing practice and the means by which nurses engage in caring
practices while giving care to prisoner-patients. For the individual nurses
involved the opportunity to articulate how they provide care for prisoners may
help them both conceptualise and celebrate their achievements. We cannot
guarantee or promise that you will receive any benefit from this project.

6. Possible Risks
The interview is not looking for particular right or wrong answers or point of
view about the questions raised. I am interested in your experiences of caring
for prisoners whatever that may entail. The interview will be relaxed and like a
conversation. As such you will be able to direct the ebb and flow of the
conversation. Although I do not expect any adverse effects or risks to you it is
possible that personal or professional issues may emerge during the discussion
that may be distressing. If you experience stress we can stop the interview at
any time and you can decide if you want to suspend or end your participation in
the project.

I appreciate that being observed while nursing a prisoner-patient in the post
anaesthetic care unit can be stressful but this observation is not intended to be
a graded examination. The idea is to relate it to gain a deeper understanding of
issues you raise in your interview. Once again at any time you can decide you
do not want to participate in this study any longer and you can withdraw at any
time you wish.

7. Alternatives to Participation
You do not have to participate in this research project, participation is
completely voluntary.

8. Privacy, Confidentiality and Disclosure of Information
At the end of the research process your name will be replaced by a pseudonym.
Any identifying features of your nursing care will be changed or removed to
protect your privacy and that of prisoners for whom you care. The data that is
gathered throughout this research project will be stored in a locked filing cabinet
or in a password protected computer when not in use. If you give your
permission by signing the consent form, the results will be published as a part of
my PhD thesis, and possibly in journals or conferences. Any published results
will not provide information in such a way that the hospital and any individual can be identified. Data will be securely stored for 7 years after which the hard copy will be shredded and the computer files deleted completely.

9. Results of Project
Upon completion of the project the results of this project will be presented in an easy to read summary and as a lecture presentation at a morning education meeting held within the operating suite at XXXX Hospital. If you discontinue your employment at XXXX and provide me with contact details, you will be sent an invitation to attend the presentation or a copy of the summary of findings.

10. Further Information or Any Problems
If you require further information or if you have any problems concerning this project, you can contact the principal researcher, Ruth Crampton; research assistant or research supervisor Dr. de Sales Turner on the following numbers:

Ruth Crampton
Phone work XXXX 4579 or pager 745

Research Assistant

Research Supervisor
Dr. de Sales Turner
Phone 9244 6960

11. Participation is Voluntary
Participation in any research project is voluntary. If you do not wish to take part you are not obliged to do so. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment, your relationship with Ruth Crampton or your relationship with St. Vincent’s Health.

Before you decide about participating, a research assistant will be available to answer any questions you have about the research project. The Research assistant (name) can be contacted on (phone number). You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify Ruth Crampton before you withdraw.

12. Ethical Guidelines
This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
The ethical aspects of this research project have been approved by the Human Research Ethics Committee of [Blank] Health and Deakin University.

13. **Reimbursement for your costs**

You will not be paid for your participation in this project.

Thank you for considering this invitation to be involved in this research project. Although you have expressed interest in being involved, as a part of the research design, there is a random chance that your name will not be forwarded to the researcher. However if your name is forwarded I hope the experience is an enjoyable and beneficial one for you.
Appendix D: Consent form and revocation of consent

Version 2 Dated 19.08.06
Site xxxx Health

Full Project Title: Exploring experiences of registered nurses caring for prisoners in a perioperative environment

I have read, and I understand the Participant Information version 2 dated 19.08.06.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

I understand that my interview will be audio taped and I give my permission for this to occur.

Participant’s Name (printed) .................................................................
Signature ___________________________ Date _______________

Name of Witness to Participant’s Signature (printed) ...........................................
Signature ___________________________ Date _______________

Declaration by researcher: I have given a written explanation of the research project, its procedures and risks and I believe that the participants as registered nurses employed by Health have understood that explanation.

Researcher’s Name (printed) .................................................................
Signature ___________________________ Date _______________

Note: All parties signing the Consent Form must date their own signature.

Optional: Participants contact details if you wish to be informed of reporting back sessions or receive copies of results at the conclusion of the research.

Address: ________________________________ Phone: _____________________________
REVOCATION OF CONSENT FORM

(To be used for participants who wish to withdraw from the project.)

[xxx Health/Deakin University]

Revocation of Consent Form

Full Project Title: Exploring experiences of registered nurses caring for prisoners in a perioperative environment

I hereby wish to WITHDRAW my consent to participate in the research project described above and understand that such withdrawal WILL NOT jeopardise my relationship with [xxx] Health or with the researcher Ruth Crampton.

Participant’s Name (printed) ....................................................................................

Signature ................................................................. Date ..................................................
Appendix E: Prisoner-patient information sheet

Patient Information Sheet

A research project that is exploring the experience of registered nurses looking after prisoners in the operating suite is being conducted at this hospital.

For this research a nurse researcher will be observing the nurse who is caring for you in the recovery area following your operation. This observation will not change the care you receive and out of respect we are seeking your permission for this observation to take place.

Participation in this research is absolutely voluntary, and if you do not want the nurse to be observed while caring for you, you can say no. If you say no, this decision will be respected and this will not negatively influence the care that you receive.

If you say yes to the nurse being observed while caring for you nothing will change in your care post operatively, except for the fact that the nurse who is caring for you will be observed.

If at any time you find this research intrusive or you would like some privacy you can ask the researcher to leave and this request will be respected.

Thank you for considering this request. If you have any questions please ask your nurse to contact the researcher.
Appendix F: Diagram of participant findings

[Diagram showing relationships between categories such as Prejudice, Horizons, Fused Horizons, and specific statements like "I try not to judge", "Prisoners require more pain relief", etc.]
Beth

Prejudice

You just want to get rid of them

Knowing makes a difference and I don’t like them

I don’t feel frightened anymore

Guards are not there to be nice

You’ve got to care

Nursing prisoner-patients is onerous

Care is rudimentary

There is an imperative to care

Horizons

Fused Horizons

Perfunctory care

Emotionally draining

Reactive care

Knowing the crime creates dilemmas

Ideal and Real
Appendices

Ruby

Prejudice

- My response depends on the guards
- (Sometimes) they are like normal patients
- I'm glad I've never known
- I am more comfortable with it now
- They deserve the best care we can give

Horizons

- Care is influenced by others
- Ignorance is bliss
- I do my best

Fused Horizons

- Perfunctory care
- Emotionally draining
- Reactive care
- Knowing the crime creates dilemmas
- Ideal and Real
Sarah

Prejudice

- I have a right to know
- We should be given a choice
- It is intimidating so I keep an arms length

Horizons

- It is important to be in control
- Care is earned not deserved

Fused Horizons

- Perfunctory care
- Emotionally draining
- Reactive care
- Knowing the crime creates dilemmas
- Ideal and Real
Appendices
Kara

Prejudice

I put up my guard

Half my brain wants to know and half doesn’t

I try to do my best so things won’t haunt me

Horizons

It is important to be confident

I restrict care

Fused Horizons

Perfunctory care

Emotionally draining

Reactive care

Knowing the crime creates dilemmas

Ideal and Real
Ryan

Prejudice

- I get a vibe from the guards
- Male nurses get more prisoners
- Prisoners are drug seeking
- Prisoners are generally OK

I don’t think about it too much

Horizons

- Perfunctory care
- Emotionally draining
- Reactive care
- Knowing the crime creates dilemmas
- Ideal and Real

Fused Horizons