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IRVINE

Care Incarcerated: The Intersection of Nurses and Law Enforcement in the Acute Care Setting

DISSERTATION

submitted in partial satisfaction of the requirements for the degree of

Doctor of Philosophy Nursing Science

in the School of Nursing

by

Danisha Jenkins

Dissertation Committee:
Associate Professor Candace Burton, Chair
Professor Dave Holmes
Professor Valerie Jenness
Associate Professor Alyson Zalta

2021

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DEDICATION

To all those who find the ways to resist the dehumanization of ourselves and others, despite the powers of the institutions we work in.

To the nurses, who leave these two years quite broken, may we find the ways to mend ourselves and each other, so that we all might reap the reward of the true potential of our profession.

To my husband, and my children, who are my reason.

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The number of brilliant minds and tremendous hearts who supported, encouraged, and taught me throughout this academic journey is astounding. My sincerest thanks to Dr. Candace Burton, whose genius and love for her work and her people is palpable. Thank you for being my cornerstone, not only in my academic work, but in a time when my job as a nurse tried to break me. You will never know the times you held me together. To Dr. Holmes, who gave me the words, and the concepts, and underpinnings to the years of feelings I had cultivated as a nurse. I could never thank you enough for the work you have done, and the doors you have opened for nurses like me to understand and make change. You gave me hope that there are more of us out there than I realized. To Dr. Jenness and Dr. Zalta, thank you for your kindness, your enthusiasm, your willingness to mentor and collaborate. Your encouragement, insights, and mentorship as committee members have been invaluable.

Thank you, endlessly, to the nurses of UC San Diego Health 5W Trauma PCU, and the Sharp Chula Vista Medical Center Critical Care service line, who supported me and cheered for me over the course of this program. I am blessed beyond reason to have witnessed daily the ways you care for people who are so violently marginalized. Thank you for the ways you love your patients, and each other. Your advocacy and perseverance are unmatched, and you will be held close to my heart forever. We were brought together in these times and spaces for a reason, and though we have walked a path I hope to never go down again, being on this journey with you all is a gift I will forever cherish.

A tremendous thanks goes to the funding bodies that supported my studies, including the Eugene Cota-Robles Fellowship, the Public Impact Fellowship, the Ellen O'Shansky Scholarship, and the Caster Institute Scholarship.

Ten years ago, when working as a nurse in the Allen County Juvenile Center, a detention center for children and adolescents in Fort Wayne, Indiana, my heart was broken. I committed at that point to study and make visible this terrifying phenomenon I was participating in; one in which nurses became tentacles of a system causing unfathomable harm. To those children, I am sorry for not knowing more when you trusted me to help. I am sorry you had to be the ones to teach me and open my eyes. This is not a burden you should have had to bear.

To my own children, Sully, Scarlett, and Scout, whose lives have never known a time in which I was not full time in both school and work. Thank you for your patience, love, and for bringing me snacks while I write. And finally, to my husband Brian, for building this life with me. I love you so fully and so sincerely, and without you, this would not have been achieved.

VITA

EDUCATION

Dates	Degree	Institution	Major
2018-2021	PhD	UC Irvine	Nursing Science
2012-2014	MS	Purdue University	Nurse Executive and Hospital Administration
2007-2011	BSN	University of Saint Francis	Nursing

LICENSES AND CERTIFICATIONS:

California Registered Nurse 850432 8/29/2013-Present
Indiana Registered Nurse 28197666A 6/23/2011-10/31/2015
NEA-BC (Nurse Executive Advance, Board Certified)
CCRN (Critical Care Board Certified)
ACLS – Current
ACLS Instructor - Current
BLS

HONORS AND AWARDS

2021 University of California, Irvine Graduate Division Commencement Speaker
2021 President's Award for Health Equity and Social Justice – American Nurses Association California
2021 Structural Empowerment Leader of the Year Award
2021 AHA Leadership Award Nominee – Nominated by Sharp HealthCare
2021 Finance PILLAR Award – Sharp HealthCare – System award for financial stewardship excellence
2021 Growth PILLAR Award – Sharp HealthCare – System award for exceeding growth targets
2021 Growth CORE Award – Sharp HealthCare
2021 Finance CORE Award – Sharp HealthCare
2021 Community CORE Award – Sharp HealthCare
2021 UCI Graduate Commencement Speaker
2020 Public Impact Fellow
2020 HealthCare Heroes Award – Nominated by ANA\C
2020 UCI Sue and Bill Gross School of Nursing P.E.O Fellowship nominee
2019 University of California, Irvine – Ellen Olshansky Founding Director's Award for Community Issues and Social Justice
2020 Sharp HealthCare CORE Award Winner – Hospital Acquired Condition Taskforce
2020 Caster Institute of Nursing Excellence Award Recipient
2018 Eugene Cota-Robles Fellowship Recipient
2018 Nurse Leader of the Year, UC San Diego Health
2018 Nurse-Led Team of the Year, UC San Diego Health
2016 Tapestry Parkview Health Sciences Award for Outstanding Women Leaders

2016 Indiana Organization of Nurse Executives Scholarship

PROFESSIONAL EXPERIENCE:

Dates	Institution and Location	Clinical or Academic Position
2019 – Present	**Sharp HealthCare**	**Director**

Director of Critical Care Services, Emergency Services, and Advanced Illness Management. Executive Chair – Sepsis Committee. Executive Chair – Code Blue and Rapid Response Committee. Executive Chair – ED Throughput. Supervise the chair of the systemwide ED Collaborative. Determines direction, goals, and objectives and ensures implementation of strategic and operating plans. Manages over 300 FTEs. Responsible of oversight and expansion of new tower and critical care surgical suites. Responsible for oversight of expansion of 4 COVID intensive care units and 7 emergency COVID treatment areas, as well as end of life support. Successful expansion from one ICU ADC of 15 to over 50. Licensed and opened surgical ICU for advanced post-operative cardiovascular patients. Expanded emergency services to include monoclonal antibody administration site and multiple advanced respiratory triage areas. Implementation of South Bay San Diego's first VV ECMO cannulation and shock services.

2020 **University of California, Irvine** **Adjunct/TA**

Lecturer for Pathophysiology, Pharmacology, and Mental Health Nursing.

2017- 2019 **UC San Diego Health** **Nurse Manager - Trauma**

Nurse Manager of 24 bed trauma progressive care unit. Spearheaded innovative organization-wide projects and approaches involving multi-disciplinary factions for systems improvement that affects patient outcomes across the organization including advanced rehabilitation care partner program, and the first to launch the acute care daily management systems. Ahead of budget financial metrics for 3 years. Reduced traveler utilization from 25 travelers to zero within 8 months. Brought unit from tier 3 to tier 1 employee engagement results for 3 years consecutively. Reduced annual overtime spending by over $200,000 annually.

2014- 2019 **Med First Inc. / Palomar Health** **Contracted RN Positions**

Critical care transport nurse. Lead instructor for ACLS courses providing certification courses and testing for nurses, respiratory therapists, pharmacists, and physicians. Per diem STAT response critical care nurse, predominantly in trauma ICU.

2013-2017 **Scripps Health** **Supervisor Patient Care**
Critical Care RN

Manager of clinical staff in critical care services including RNs, telemetry technicians, and certified nursing assistants.

2011-2013 **Parkview Health/ University of St. Francis/ ACJC** **Critical Care Nurse**
Community RN
Adjunct Faculty

Clinical RN in Surgical/neuro/trauma intensive care unit at 446 bed not-for-profit Level-II regional medical center. Trauma RN. Provided nursing services at intake and throughout incarceration to detained juveniles. Authored, implemented, oversaw, and managed facility medical protocol for 115 bed juvenile detention facility in collaboration with university. Managed the research and publication of state and federally regulated medical care guidelines. Responsible for audits and statistical analysis of current medical procedures for evidence-based practice and patient outcomes. Responsible for oversight and training of medical and non-medical staff in regulatory requirements for juvenile care.

PUBLICATIONS

Jenkins, D., Burton, C., Holmes, D. (2021). Hospitals as Total Institutions. *Nursing Philosophy.* In review.

Jenkins, D., Burton, C., Holmes, D. (2021). Re(Defining) nursing leadership: on the importance of parrhesia and subversion. *Journal of Nursing Management.* In review.

Jenkins, D., Burton, C., Holmes, D. (2021). "We're Not Caring Angels": The Influence of Gender Dynamics at the Collision of Caring and Carceral Institutions. *Advances in Nursing Science.* In review.

Jenkins, D., Holmes, D., Burton, C., Murray, S. (2020) 'This is not a patient, this is property of the state.' Nursing and the immigrant detention apparatus. *Nurse Inquiry,*27(3), *e12358.*

Jenkins, D., Davidson, J., Cederquist, L. (2018). The ethics of law enforcement in the inpatient setting. *Society of Critical Care Medicine. Fall 2018, 28-29.*

Jenkins, D., Harrison, S. (2013). The impact of electronic personal health records use on health outcomes among Type II Diabetes Mellitus patients. *Midwest Alliance for Health Education, 14-19.*

Jenkins, Danisha. (2011). Bridging the divide: A change for our future. National Student Nurses Association. Retrieved from www.nsna.org.

PROFESSIONAL PRESENTATIONS

Jenkins, D. (2021). Expert Panelist. Pandemic Operations – Lessons Learned. Association of California Nurse Leaders.

Jenkins, D. (2021) *This is not a patient, this is property of the state.* Oral presentation and expert panelist at International Law Enforcement and Public Health Conference.

Jenkins, D. (2020) *Separation, detention, and deportation: How US immigration policies threaten access to healthcare.* Expert panelist at Amnesty International General Assembly.

Jenkins, D., Lauzon, V. (2020) *The use of rehabilitation care partners to reduce workplace violence in a trauma setting.* Podium presentation. Academy of Consultation-Liaison Psychiatry International Conference.

Jenkins, D., Meyer, A. (2019). *Restraint utilization with certified nurse assistants versus video monitoring.* Poster Presentation. ACNL San Diego Innovations Conference.

Jenkins, D. (2019) *Improving Outcomes for Traumatically Brain Injury Patients through Transdisciplinary Lean Problem Solving.* Podium presentation. UC San Diego Health Research Conference.

Jenkins, D. (2018). *The process of inquiry and innovation: Evaluating the Ethics of Law Enforcement in the Inpatient Setting.* Keynote presentation. San Diego Association of Hospital Risk Management.

Jenkins, D. (2018). *Reducing delirium and restraints in traumatically brain injured patients.* Poster presentation. Association of California Nurse Leaders. People's Choice Award.

Jenkins, D. (2018). *Reducing delirium and restraints in traumatically brain injured patients.* Poster presentation. CALNOC State Conference

Jenkins, D. (2018). *The process of inquiry and innovation: Evaluating the Ethics of Law Enforcement in the Inpatient Setting.* Keynote presentation. Association of California Nurse Leaders Conference.

Jenkins, D. Meyer, A., Lauzon, V. (2018). Restraint utilization with certified nurses assistants versus video monitoring. Poster presentation. Academy of Consultation Liaison-Psychiatry National Conference.

Jenkins, D. (2018). *What is a PCU Nurse?* Podium presentation. UC San Diego Health PCU Conference.

Jenkins, D., Harrison., S. (2013). *Parkview ePHR and information prescription in diabetes impact (PEDI) trial: The impact of electronic personal health records use on health outcomes among type II Diabetes Mellitus Patients.* Podium presentation. Midwest Alliance for Health Education.

Jenkins, D. (2013). *New graduate nurse residency.* Podium presentation. Parkview Health Annual Nurse Leaders Conference.

Meyer, AA, Jenkins, D., Vandersall, B., Lauzon, VL. Restraint utilization with certified nurse assistants versus video monitoring. *UC San Diego Health Annual Journal.*

RESEARCH ACTIVITY:

2020 – Student investigator of NIH funded study "Examining the nature and consequences of moral injury in frontline nurses during COVID-19".

2020 – The Interactions of Nurses and Law Enforcement in the Acute Care Setting – Interpretative Phenomenological Analysis

2018 - present – Referee/ Reviewer: Journal of Nursing Administration

2017 – Restraint Utilization with Certified Nursing Assistants versus Video Monitoring. Co-investigator and author for NIH funded research on restraint reduction measures in the inpatient setting, and impact of remote video monitoring on restraint utilization versus trained bedside safety coaches.

2013 Co-investigator and author of federally funded interdisciplinary research in primary care for national study of Type II DM and EMRs with ACA standards. Oversaw protocol development and IRB approval process, data collection, and training implementation.

COMMITTEE INVOLVEMENT AND OTHER ACTIVITIES:

Ethics Advisory Board – American Nurses Association Center for Ethics and Human Rights – Appointed Board Member
California Coalition for Reproductive Freedom – Nurse Liaison for ANA\C
Legislative Committee – American Nurses Association California
San Diego Region ANA\C Taskforce - Chair
Crisis Standards of Care Committee – Entity nursing and ethicist representative for crisis standards planning and operational implementation related to crisis pandemic resource allocation
Highly Infectious Disease Committee – Entity leadership meeting for operations and planning for disaster and pandemic planning
Committee Chair – Entity Sepsis Committee Sharp HealthCare
Committee Chair- Entity Code Blue Committee Sharp HealthCare
Elected California representative - ANA Membership Assembly
ANA\C Committee on Racial Justice
SDACNL Committee on Racial Injustice and Healthcare Disparities
Safety and Disaster Committee – Sharp HealthCare
Chair - ANA\C San Diego Regional Taskforce
Medication Error Reduction Committee – UC San Diego Health
Human Trafficking Committee – UC San Diego Health
Threat Assessment Committee – UC San Diego Health
Leadership Oversight Council – UC San Diego Health
Health Policy Committee – ANA\C
California representative - #EndNurseAbuse policy development panel American Nurses Association Professional Issues Panel

PROFESSIONAL ORGANIZATION MEMBERSHIP and Leadership:

American Nurses Association – Ethics Advisory Board Appointee Center for Ethics and Human Rights
Board Appointed Coalition Liaison Representative – California Coalition for Reproductive Freedom
ANA\C San Diego Taskforce Chair
ANA Membership Assembly Elected Representative
Association of California Nurse Leaders
American Nurses Association
American Association of Critical-Care Nurses
Sigma Theta Tau

Volunteer Work

2020 – Present. ANA\C Nurse task force protest response. Lead group of registered nurses providing emergency first response, COVID prevention education, resources to the unhoused, at over 100 direct actions.

2020 – Umoja Community Garden – Volunteer at community garden which provides education on self-sustenance, food to the community, water, and resource distribution to the unhoused.

2018- Present. Stop the Bleed® instructor. Provide community education on lie saving intervention to stop catastrophic bleeding.

2020- Volunteer with interdisciplinary group providing ongoing education, patient care support at Tijuana General Hospital and Mexicali General Hospital in the COVID- 19 Crisis. Coordinated daily nurse volunteers to provide hands on support and training on manual pronation therapy and oxygenation techniques.

ABSTRACT OF THE DISSERTATION

Care Incarcerated: The Intersection of Nurses and Law Enforcement in the Acute Care Setting

by

Danisha Jenkins
Doctor of Philosophy in Nursing Science
University of California, Irvine, 2021
Associate Professor Candace Burton, Chair
Professor Dave Holmes, co-Chair

Abstract

Caring for people accused and convicted of crimes is a required duty for many nurses working in acute care settings. For the registered nurses engaged in the provision of this care, strict adherence to professional ethics and expectations of usual care may be challenged by the presence of or interaction with custodial officers. The purpose of this study was to give voice to the lived experiences of nurses and law enforcement officers who interact with one another in the hospital setting, while gaining understanding of their individual perspectives and unique experiences, and how they interpret these experiences. The aim of the study was to understand the lived experience of nurses and law enforcement officers when interacting with one another in the hospital; particularly the ways they perceive their role and responsibilities in this dynamic, their experiences with self-efficacy and moral injury, their perceptions of power, and ways in which nursing standards of care are affected. Data were collected via semi structured interviews. Interviews were completed by 10 registered nurses and 9 law enforcement officers. The results of the study demonstrate complex perceptions and operationalizations of power and control, as well as reflective meaning-making behind the underpinnings of an increasingly contentious dynamic.

Chapter 1: Introduction

Caring for people accused and convicted of crimes is a duty required of many nurses in acute care settings. Patients in custody increasingly receive medical care in hospital settings; accounting for about 20 percent of prison healthcare spending (National Research Council, 2014). For the registered nurses engaged in the provision of this care, strict adherence to professional ethics and expectations of usual care may be challenged by the presence of or interaction with custodial officers. Research conducted in corrections settings has shown that the tensions between custody and care have a decidedly deleterious effect on nursing practice (Holmes, 2005). Law enforcement is tasked to keep the patient under strict surveillance, and paradigms of control and punishment can interfere with and ultimately impede the delivery of nursing care by restricting, altering, and/or deforming the nurse-patient relationship. Where the institutions of custody and care collide, nurses may be forced to choose between complying with law enforcement demands and constraints or practicing nursing according to recognized standards of ethical care. In fact, nurses may be unable to choose because that “choice” is made for them by policy or procedure.

Incarcerated patients are an identified vulnerable population according to the Centers for Disease Control and Prevention (CDC, 2014). Given the disproportionate rates at which people of color, people living with mental illness, and migrants are detained and incarcerated, it is all the more critical to investigate the forces that influence or worsen disparities in care among the incarcerated. This study seeks to understand the forces contributing to and the corresponding sequalae of the tension within this socio-ecological care versus custody dynamic, as well whether or not and if so, how the tension impacts nurses’ care of this vulnerable population. Understanding how forces of control influence what nurses can and cannot or will and will not

provide for patients as well as for law enforcement can inform approaches to shielding vulnerable patients from detrimental effects in such encounters.

The study sought to answer the research question: What are the lived experiences of registered nurses and law enforcement officers in the acute care setting when they are brought together due to a patient in their charge? Particularly, how do they perceive their roles and responsibilities in this dynamic, what are their perceptions of power, are feelings of impaired self-efficacy and moral distress experienced, and in what ways are nursing standards of care affected? The collection of data on these experiences makes an important contribution to the theoretical and philosophical body of literature on biopolitics within institutions and makes visible the ways in which power and control are operationalized between nurses and law enforcement officers. Participants in this study provided striking and powerful examples of and reflections on the detrimental effects of interactions between nurses and law enforcement that happen with relative frequency. However, this contentious dynamic is barely known and hardly discussed, except behind institutional walls. As incarceration rates remain high, and hospitals and law enforcement departments become further corporatized and institutionalized, this study offers an in-depth view into the lived experiences of those wielding power therein, whose decisions and actions can greatly affect the patient in their custody and/or care.

This dissertation is composed of an introductory chapter followed by three chapters representing separate manuscripts prepared for publication, followed by a final chapter in summation. Chapter two is titled "Hospitals as Total Institutions," and through the philosophical and theoretical lens of Erving Goffman, explores the ways in which hospitals in the United States utilize totalizing practices, and the ways in which these purported places of healing do in fact fit the total institution mold. The third chapter titled ""So There. I Won": The Struggle for Power

Between Caring and Carceral Institutions" examines the lived experience of nurses and law enforcement officers in the hospital setting and focuses on themes related to power struggle. This chapter presents qualitative findings, identifying overall themes that emerged from the data. Each participant spoke with the primary investigator about their experiences in a semi-structured interview. Chapter four is titled ""We're Not Caring Angels": Gender Influences in the Collision of Caring and Carceral Institutions" and reports further significant findings related to the dynamics of nurses and law enforcement interactions. This paper focuses on gender dynamics, a major theme in the data, and explores perceptions of patriarchal influence and control as poignant and resounding influence on the conflict experienced between nurses and officers. Finally, the fifth chapter is a summary and synthesis of the preceding chapters, and includes recommendations for further research.

Theoretical Framework

Before data collection, applicable theoretical and conceptual constructs were evaluated. There were no nursing theories to draw from, however philosophical and theoretical underpinnings from other disciplines were studied to design a conceptual model. The social phenomenon explored in this study and corresponding analysis of the complexities of the interaction benefit from a wide body of knowledge gleaned from multiple disciplines (Jabareen, 2009). Foucault (1975) and Agamben's (1995) work on biopolitics were foundational to this work, which also draws from relevant empirical and theoretical literature including Goffman and feminist theory to present a proposed conceptual model of the studied phenomenon. The theoretical and philosophical underpinnings of total institution, feminist theory, and phenomenology were mobilized in conducting the research.

The conceptual model (see Figure 1) illustrates the collision of two power-wielding parties who otherwise operate within their own total institutions. The person detained (from the perspective of law enforcement), who is also the patient (from the perspective of the nurse) draws into collision political actors from two different institutions. This collision occurs within a biopolitical space that exists and functions within the totality of sovereign biopower, where the state of exception is both fundamental and uniquely operationalized. The prescribed and socially constructed function of professional roles and responsibilities as they relate to the patient who is detained are, as illustrated, diametrically opposed. This opposition may lead to a struggle for power and decision making that ultimately ends with concessions in correctly completing one's job duties. For nurses, when those duties are ethically bound by what is *good* and *just* and aligned with a world view of what is *right*, making concessions can result in distress, such as experiences of impaired self-efficacy and moral injury, as well as perceived alterations in standards of care provided. The forthcoming sections provide context to the theoretical and philosophical underpinnings of the major elements presented in the model.

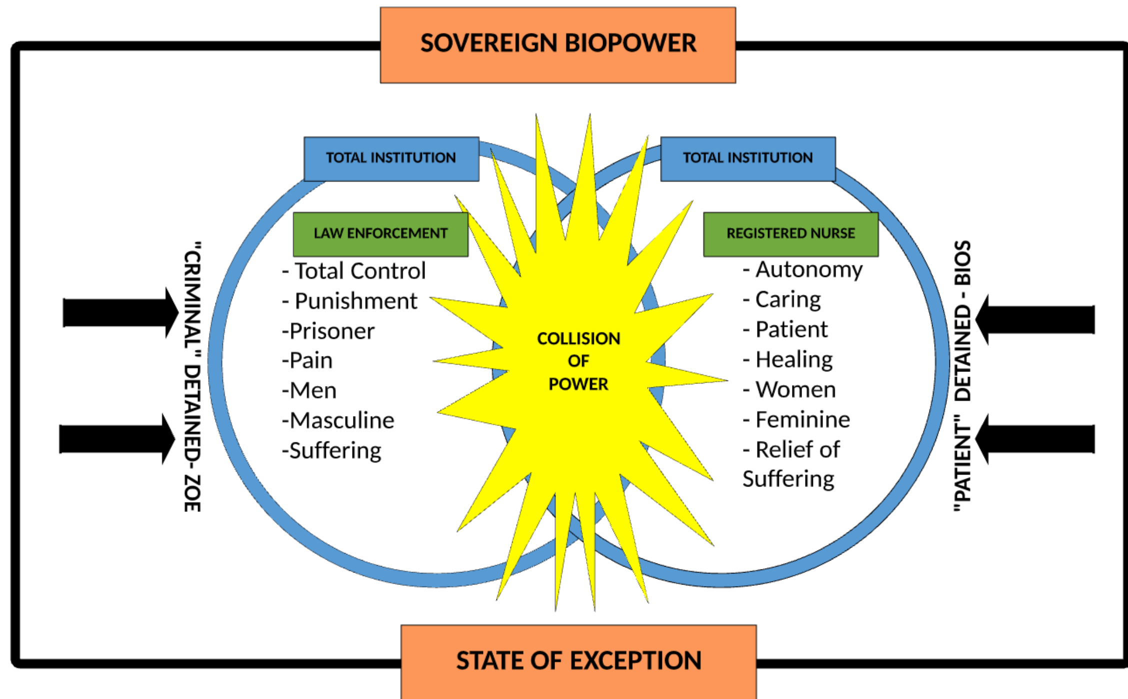


Figure 1. Conceptual model.

Sovereign Biopower

Foucault (1975) analyzed and described the evolution of the various forms of punishment as power manifestations throughout history. Of importance to this study is the conceptualization of the sovereign's historical right to punish, and how this power was applied to the criminal body. Biopolitics is the method by which modern power structures operate to "ensure, sustain, and multiply life, to put this life in order" (Foucault, 1978, p. 138). Nurses necessarily thus operate in biopolitical spaces and analysis of the relationships of power is critical to understanding the social nursing processes that contribute to suffering or act as barriers to the expression of compassion and caring (Georges, 2014).

Agamben's (1995) conceptualization of biopolitics further differentiates between bare biological life and political life using the Greek terms zoe and bios. Political life (bios) hinges on human capacity to speak and to be represented and recognized in the public space as an

autonomous human. Zoe is the barest of life identifiable only in its organismic or biological capacities. Agamben asserts that zoe "remains included in politics in the form of the exception, as something that is included solely through an exclusion" (1995, p. 11). Agamben illustrates the extremes of these dehumanizing practices and structures in environments such as concentration camps (Agamben, 1995), however, there are jarring examples of the lengths to which nurses have gone, and will go, for biopolitical self-preservation in the fragile nature of zoe/bios paradox. History offers severe exemplars of Agamben's assertion that every action in which we engage is situated around the risk and avoidance of becoming "bare life": nurses exerted deadly authority and withholding of care to Indigenous students in residential schools in both Canada and the United States (Bourque Bearskin, Munro, Symenuk, & Tisdale, 2020), and were executors of the calculated killing of "mentally ill" patients under the Nazi regime in Germany (Foth, 2013). Today, nurses debate their participation in legal executions (Shields et al., 2018), and struggle through navigating where they, and their patients, fall in the biopolitical hierarchies of the immigrant detention apparatus (Jenkins, Holmes, Burton, & Murray, 2020).

In every day practice, patients can be quickly be relegated to zoe status at the hands of nurses through engaging in behaviors like substance abuse (da Cunha, 2015), through obtaining such labels as "non-compliant" or "frequent-flyer" (Olsen, 2019), or as a result of socially constructed differences like sexual orientation (Georges, 2014), gender identity (Saewyc, 2017), or poverty (Diniz, Castro, Bousfield, & Figueira Bernardes, 2020). In following Agamben's philosophy, such dehumanizing ascriptions illustrate even the primacy of maintaining employment in a capitalist health care system (Georges, 2014, p. 9). The zoe – bios dichotomy is so deeply ingrained in such a system, that it becomes operationalized with ease and without thought. Nurses both enforce, and are subject to biopower, and may become unwitting

participants in maintaining these dehumanizing practices as they “scramble to stay on the bios side of the margin” (Georges, 2008). The influence of law enforcement as holders of absolute power *over* the incarcerated individual compounds this degradation of political agency where the two professions must engage with the individual in question.

Similarly, Foucault defined biopolitical power as one in which a new legal and administrative scaffolding works to “incite, reinforce, control, monitor, optimize, and organize the forces under it: a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them” (Foucault, 1978, p. 136). Biopolitics is the method by which modern power structures operate to “ensure, sustain, and multiply life, to put this life in order” (Foucault, 1978, p. 138). These Foucauldian tenets offer critical philosophical and theoretical guidance to this study. Foucault (1975) analyzed and described the evolution of various forms of punishment as manifestations and operationalizations of power throughout history. Of particular relevance here is the sovereign’s historical right to punish, and how this power was applied to the criminal’s physical (or zoe) body. While historical punishment by the sovereign power was exhibited ceremoniously and publicly, punishment has become an increasingly covert “legal or administrative practice” (Foucault, 1975, p. 8). Historically, power was operationalized through the public execution of a person, however the modern sovereign biopolitical force asserts influence throughout the populace and thereby finds greatest efficiency when operationalized via healthcare and corrections systems. Biopower thus operates not from a central locus of (sovereign) control but is applied diffusely, anonymously, legally and administratively through everyday networks of state institutions, including the military, police, medical, and legal systems, in such places as schools, hospitals, and prisons (Foucault, 1978, p. 140). The conceptual model illustrates the active

collision of law enforcement and nursing practices that exists as a result of this diffusion of sovereign power and the corresponding stronghold of the states of exception weaponized in the associated biopolitical spaces.

The State of Exception

Agamben expanded Foucault's work on biopolitics to succinctly define sovereign power as: "he who decides on the exception" (Schmitt, 2006, p. 5). The "state of exception" is the right of the sovereign to suspend the rule of law, or to act in an extralegal capacity, in classification of persons. Agamben argues that the state of exception is used by modern governments as a method to regulate the actions of the population and writes that "modern totalitarianism can be defined as the establishment, by means of the state of exception, of a legal civil war that allows for the physical elimination not only of [a sovereign's] political adversaries but of entire categories of citizens who for some reason cannot be integrated into the political system" (Agamben, 1995, p. 2). In deciding and assigning the exception, the sovereign operates both within and outside of the confines of law and is empowered to enact punishments, constraints, or rules even in suspension of the law it ostensibly exists to uphold (Colebrook & Maxwell, 2016). For Agamben, they who decide the exception hold the power, and it is the sovereign who can render an individual outside of or beyond the rule of law, effectively snuffing the political (bios) life of the individual—potentially including rights to access medical care, to consent to or refuse treatments, and/or to attain the highest levels of self-actualization (Hankivsky et al., 2017). The individual is thus fundamentally reduced to zoe. While some existing literature demonstrates the impact of suspending such political existence and the associated rights (see for example Jenkins, Holmes, Burton, & Murray, 2020), the how, why, and by whom states of exception are operationalized in nurse-law enforcement interactions was further investigated in this study.

Total Institution

The convergence of "registered nurse" and "law enforcement" within the colliding institutional circles conceptualizes the duties and characteristics of the acting players from two different total institutions. Total institution is defined as "a place of residence and work where a large number of like-situated individuals cut off from the wider society for an appreciable period of time together lead an enclosed formally administered round of life" (Goffman, 1968). Goffman's typology of delineating characteristics that qualify a system as a total institution include being established to care for people who are presumed to be harmless (hospitals), and being organized to protect the community against those felt to be imminent dangers where the welfare of those included is not an immediate issue (prisons and jails) (Goffman, 1968). The daily activities of total institutions are thus generally planned to meet the needs of the organization rather than the individual (Goodman, 2017). In normal circumstances and in the confines of their own biopolitical and (total) institutional spaces, nurses and law enforcement professionals perform their roles with largely unquestioned assurance.

Because of the priority of organization over individual, the ways in which a person functions inside such an institution can be very different from how they function outside of the institution. Total institutions are characterized by the bureaucratic control of the actions and needs of a group of people, and institutional success relies upon a 'mortification of self'(Goffman, 1968). The process of mortification of self occurs through such processes as role dispossession, in which one loses the identity of the role they previously occupied in society and then identifies with the role they play in the organization (i.e., nurse or law enforcement). This transformation detaches the individual from normal and autonomous decision making, such that actions and choices become driven by role and behavior expectations that serve the institution.

The process is amplified as self-determination is further restricted through bureaucratic controls over decision-making (Goodman, 2017). Given that both hospitals and carceral systems operate within the stringent processes and expectations of total institutions, this conceptual model seeks to guide the study in answering the questions: Are decisions being made by the individuals overseeing the care of these patients guided by individual and autonomous thought processes or are they particularly and specifically in service of the total institution? To what degree does a self-mortification process occur in nurses and law enforcement officers, how does that process alter their relationships with those in their charge, and is there perceived collateral damage to the individual? Ultimately, what are the lived experiences of key players from two total institutions when the bounds of those institutions are forced to collide?

It is further important to consider the significance of the institutional origins of both types of professional. In the context of care vs. custody, the locations of interactions between nurses and law enforcement carry significant import. If the 'place' of custody suggests a reductive view of bodies as physical objects (Casey, 1997), does a change in the social experience of the 'place' of care change the basis of ethical nursing practice? Both the institution of the hospital and the institution of the prison system are built upon significant power relationships – there are defined understandings in each institution of who controls movement, activities, treatment, and whose interests are to be served (Goffman, 1968)—but these differ wildly between the two. Nurses are often aware of the ways in which the clinical setting is already inherently structured by power relationships, and have become skilled in navigating these relationships, only to have their professional action pathways necessarily disrupted by the introduction of the enforced power and control ideology of law enforcement. In a phenomenological investigation of the clinic setting, Foucault (1973) discussed the power implications that contribute to the practice of "care" itself.

Through this lens, nursing care is reconceptualized as a means of exercising power, caring is shown to be related to control of the patient and the environment, and knowledge creation is only that which empowers the nurse (Gastaldo & Holmes, 1999). The results of this study help to situate the intersection of these two institutional powers in the larger domain of the biopolitical space of healthcare and to identify where they diverge, converge, and the resulting outputs.

Feminist Perspective, Moral Injury and Distress

Foucault argued that knowledge and power are coincident, and that men have traditionally been the ones to define what knowledge is, and what it is not (Foucault, 1978). Knowledge, as constructed on this patriarchal scaffolding, thus limits scholarly discourse on gender-power relationships via dichotomous definitions of women/men and femininity/masculinity (Leonard, 1984). The concepts men/women and masculine/feminine are presented in opposition within this model's colliding circles, because this topic of study is closely tied to power struggle and power structure from institutions nearly monopolized by binary male (law enforcement) and female (nursing) gender identities. In fact, approximately 85% of gender-identified registered nurses in the study setting are female (Rappley, 2015) and approximately 84% of gender identified law enforcement officers are male (SDPD, 2019),

Feminist theory is thus a critical lens through which to analyze the interactions of interest as well as the institutional conflicts. In her work on gender and power in organizations, Nicolson asserts: "Gender relations are the site for power struggles and power-based conflicts in work organizations… power remains firmly in the hands of men, although not without resistance…." (Nicolson, 2015, p. 54). Feminist theory guided-research seeks to understand gender inequality through examining social roles, expectations, and experiences, and focuses primarily on analyzing gender inequalities through dissection of experiences of discrimination,

objectification, oppression, stereotyping, or patriarchal behavior (Brabeck & Brown, 1997). This is a crucial consideration for binarized professions as are studied here, not least because moral distress related to nursing identity and responsibility has been studied through a feminist lens and found to result from dichotomies between nurses' self-image and their place in the power hierarchy (Peter & Liaschenko, 2012). Nurses are necessarily knowledgeable and competent professionals, who exercise power by virtue of their expertise in clinical practice—yet they are often subjugated to other providers or to constructions of the profession that silence and devalue their contributions (Burton, 2020). The application of a critical feminist lens to this work, then, offers opportunities to explore further biopolitical dimensions of interaction between nurses and law enforcement.

The Researcher's Role

It is the researcher's responsibility to protect participants from risks and harm throughout the study. In qualitative methodologies, the researcher acts as a data gathering instrument whose function is to elicit detailed responses through effective study protocols and conduct of interviews. As part of the interpretive phenomenological analysis (IPA) methodology, the researcher engages in the "double hermeneutic" of seeking meaning from participants' efforts to make sense of experience (Smith, Flowers, & Larkin, 2009, p. 3). The researcher is also responsible for participating in reflexive practices and sustaining awareness of their role in the co-construction of knowledge, and to make explicit the inter-subjective realities which may influence data collection and analysis (Finlay, 2002a). Through reflexive processes, the researcher works to enhance accountability and transparency. Reflexivity has been found to be a valuable tool in examining the impact of the position and perspective of the researcher, promoting insight through examining individual responses, exploring and discussing implicit

biases, evaluating research methods, and welcoming public scrutiny of research integrity (Finlay, 2002b). In this regard, I position myself as the Director of Critical Care and Emergency Services, and previous nurse manager of an acute care trauma department from which participants for this study may have been drawn. Power dynamics in this exchange are inevitable, and the disproportionate power between participants and researcher may affect the way in which knowledge is generated (Van der Riet & Boettiger, 2009). This challenge was addressed, in part, by the fact that participation was entirely voluntary, and the sample was also drawn from departments that I do not directly supervise. Additional protections were offered, including participating in the interview entirely anonymously, if participants preferred. It is additionally important to acknowledge that I, as the researcher, share many characteristics of the nurse study participants. I am a registered nurse with ten years of experience interacting with law enforcement in the hospital setting. My position and experience provided an opportunity for a rich body of data, as I am a known and trusted figure who has spent many years collaborating with nurses and law enforcement officers in caring for patients in custody. Additionally, I sought feedback and ideas from both nurses and law enforcement officers on the types of questions that were important to ask in the interviews and about what they as participants hoped we could learn from the study.

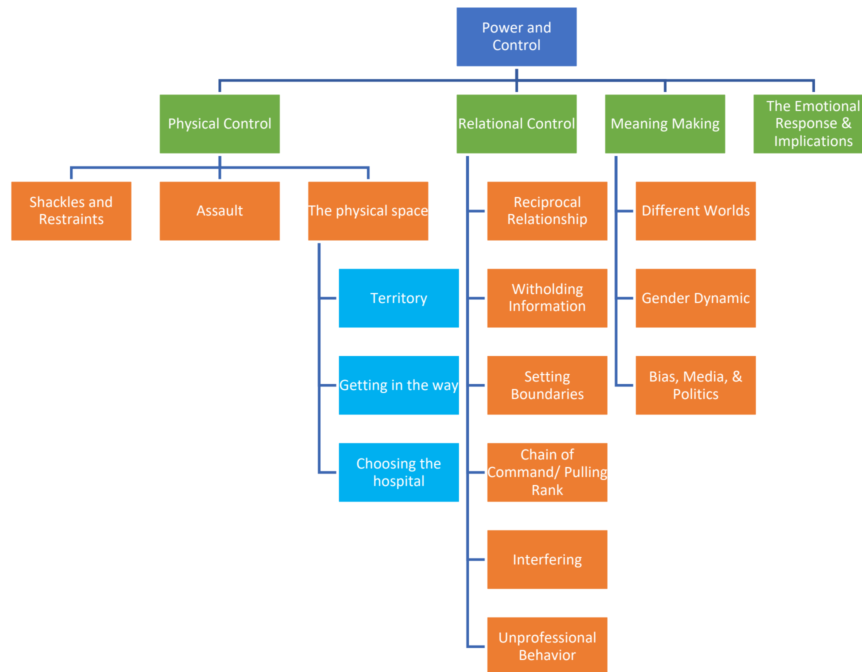
Through the hermeneutical cycle (Smith et al., 2009), I identified and examined similarities in participants' accounts. I made note of themes brought forward by individual participants which were new, to further evaluate and search for in the data, in the case that the themes re-emerged throughout the data analysis. This process was repeated with each interview transcript and then patterns in the themes were identified across participants. The data were analyzed following IPA methodology. Analysis of qualitative data moves from the particular to

the shared, and from the descriptive to the interpretive (Smith et al., 2009, p. 79). This research methodology is grounded in a postmodernist approach, which asserts the heterogeneity and contextuality of knowledge (Kvale, 1994). While it is obvious that statistical generalizability is not relevant for a qualitative study, analytical generalizability was sought. Analytical generalization "involves a reasoned judgement about the extent to which the findings from one study can be used as a guide to what might occur in another situation" (Kvale, 1994, p. 233). Analysis followed a cycle that is both iterative and inductive using coding. The IPA steps as delineated by Smith et al. include: (1) "immersing oneself in the original data" by listening intently to the audio recording and reading and re-reading each transcript (p. 82); (2) "examining semantic content and language" of the data to identify and note content of interest (p. 83) (3) "analyzing exploratory comments" from the first analysis to identify and develop emergent themes within the data(p. 91), (4) discover for connections across emergent themes by utilizing abstraction, polarization, contextualization, numeration, and function (pp. 96-98); (5) moving to the next data set to repeat the process; and finally (6) looking for patterns across cases.

Upon completing data analysis, I began to look for patterns and themes across all accounts. At this stage I became aware of strong connections in relation to some theme areas, weaker ones in relation to others, and in some cases isolated instances that did not fit with any other descriptions. Under the overarching umbrella of Power and Control, this resulted in the identification of four superordinate themes and multiple subthemes, as shown in the findings, and depicted in the figure below.

Figure 2

Illustration of themes



The forthcoming chapters consist of three papers that present and discuss some of the results and conclusions drawn from this study. Particularly, the justifications behind asserting hospitals as total institutions, the physical mechanisms of control, and the gender influences impacting the studied interaction.

Chapter 2

Hospitals as Total Institutions

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Abstract

The image of the hospital is socially constructed as a place of healing. Though the oft criticized total institutions of the past have been notably dismantled, the totalizing practices therein are now operationalized in the health care system. Through the lens of Erving Goffman, this paper offers ways in which health care institutions operationalize totalizing practices, contributing to the mortification of patients and nurses alike in service to the bureaucratic machine.

Keywords: *Total Institution, Goffman, autonomy, caring*

Hospitals as Total Institutions

The image of the hospital is socially constructed as a patient-centered place of healing; a haven for people to recover from injury and disease, receive necessary treatments and monitoring and above all, a safe place to receive *care*. Though the oft criticized total institutions of the past including tuberculosis sanitaria and large mental institutions have been nearly dismantled, the *totalizing* institutional practices embodied therein have, in many ways, found a way to remain extremely present within our actual health care system. While it should readily be possible to preserve autonomy and provide for healing in a person-centered environment, the corporatization and capitalist-driven heartbeat of health care, as well as a dearth of community and public health resources, has led to the institutionalization of hospitals. These institutions in turn exhibit varying degrees of totalizing practices. In privatized, corporate health care models, the needs and desires of the patient may be incongruent with the productivity of the organization, and various methods of control may be exerted to preserve productive caring operations. The bureaucratic practices, policies, and rules associated with the administration of *care* and *safety* in hospitals may serve as barriers to their oft-espoused person-centered narrative, as well as act against the preservation of autonomy of patients and nurses upheld by the nursing profession. Particularly, methods of control and surveillance over patients and nurses alike, usually most strictly used on the most marginalized of populations, may result in poorer outcomes for patients and role conflict for nurses. This paper examines the ways in which modern acute care hospitals embody Erving Goffman's definition of "total institution", and the mechanisms by which mortification of self is operationalized behind contemporary hospital walls.

Goffman's Total Institution

In society, there are certain organized social groups that promote separation, isolation, and strict monitoring by way of physical structures and institutional rules. In these social organizations exists a division between those who are supervised, and those who do the supervising (Serpa, 2018). In his 1961 book titled *Asylums*, Canadian sociologist Erving Goffman defined such social organizations as total institutions, or "a place of residence…where a large number of like-situated individuals cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (Goffman, 1968, p. xiii). Goffman's identified characteristics that qualify systems as total institutions are those entered via both voluntarily and involuntarily, including institutions established to care for people who are presumed to be both incapable and harmless (i.e. homes for the blind, orphanages), institutions for persons deemed incapable of caring for themselves and who may pose a threat to the community (i.e. mental hospitals or halfway houses) and institutions organized to protect the community against what are felt to be intentional dangers, in which the welfare of the people therein is not considered an immediate issue (prisons and jails) (Goffman, 1968, p. 4).

The modern acute care hospital is not explicitly listed as an example of a total institution in Goffman's original text, however in the early 1960s the landscape and structure of healthcare delivery was quite different from today. Institutions like tuberculosis sanitaria were largely shuttered by the late 1960's (D'Antonio, 2020). After chlorpromazine© was offered as a promising cure for severe psychiatric symptoms, and most psychiatric facilities were closed even without sufficient community-based alternatives, thousands of people with severe and

debilitating mental illnesses were pushed into homelessness, local jails, and often in their times of greatest crisis held against their will in general acute care hospital emergency department or inpatient beds (Ollove, 2016). This drastic evolution of the healthcare landscape pushed more care delivery away from person-regulated environments, and behind the walls of institution regulated environments: hospitals. While several of Goffman's manifestations of total institutions may have been at least partially dismantled in their physical forms (tuberculosis sanitaria, mental institutions, etc.), the relevant social processes have remained. With regard to the hospital environment, many of the intensely isolative processes in particular have been subsumed.

Another important characteristic of today's general acute care hospital that differs from the time of Goffman's writing is the dramatic change in incarceration rates and necessarily related models of healthcare delivery. By the 1970's the United States began a dramatic upward trajectory in imprisonment rates. By 1985, 312 out of every 100,000 residents was incarcerated, and by 2005 that increased to 743 per 100,000 (Wildeman & Wang, 2017). These numbers do not include the over 500,000 persons in immigration detention centers in the United States (Stickney, 2019). In a country where mass incarceration is pervasive, patients in custody are receiving an increasing amount of medical care in hospital settings (Jeremy Travis & Western, 2014): hospital care accounted for about 20 percent of prison healthcare spending between 2007 and 2011. This suggests a necessary collision (or dramatic collusion) of institutions, of which the ramifications are exponentiated by the *totalitarian* characteristics inherent in each. The complex matrix of biopolitical power relationships (Foucault, 1973; Hacking, 2004), and a historic building of panoptic surveillance in healthcare (D. Holmes, 2001) has provided for the transfer

of totalizing practices from the Goffman's decrepit total institutions of the past, to modern acute care hospitals.

Hospitals as Total Institutions

Total institutions are generally characterized by the bureaucratic control of the human needs of a group of people, operationalized through multiple techniques such as mortification of self. Today's general acute care hospitals share many, if not all of the attributes that define total institutions. These similarities are not lost on patients, particularly those seeking services for mental illness, nor on nurses whose very steps may be tracked by hospital administrators seeking to maximize "efficiency." As a patient participating in a qualitative study on experiences with mental health care in an emergency department stated:

> And then the security would come in and start yelling at me and holding me down, restraining me. I think it's what was had to be done at the time, but I think the security need to be trained a little better as far as how they handle people. That was, you know, an episode: Me screaming at the top of my lungs. I was screaming. But as a human being, as someone with feelings, even though I was acting irrationally, I actually needed their compassion (Vendyk, Young, MacPhee, & Gillis, 2018, p. 593).

Mortification of Self

To maintain bureaucratic control and efficiency of operations, total institutions specifically require mortification of self. Goffman described that the person comes into such an institution with a conceptualized self-identity that was created, in part, by arrangements in their home world (domestic identity). It is through mortification of self that they shed the personhood which served this sense of self and take on the role and identity which serves the institution (identity of the patient). The person is stripped of the "domestic" identity and support provided by "outside"

arrangements, and through “a series of abasements, degradations, humiliations, and profanities of self” (Goffman, 1968, p. 14), a radical change in personhood occurs. Mortification of self occurs through a dispossession of role, a loss of identity, and a devolvement of autonomy that one holds on the “outside.” Patients with very short hospital stays may not suffer the fullest extent of bureaucratic control, and the degree to which the individual is permitted autonomous decision making also determines the degree to which mortification is complete. While Goffman failed to deeply investigate the mortification of people other than the “inmates” of a total institution (Peshkin, 2001) , we see that nurses who work in outpatient or less regulated clinical settings may have greater autonomy over everything from their working attire to when and what they choose to eat while at work than do nurses in strictly regimented acute care environments such as intensive care units, locked psychiatric units, or surgical procedure suites.

Upon entrance to the hospital, one must leave behind the autonomous role one plays outside of hospital walls. Inside the hospital, a person may be become a patient or a nurse, generally cohorted with other similar patients or practitioners, often referred to by their diagnosis or specialty area. The person is expected to take on the newly imposed roles of patient or nurse, amenably and compliantly receiving or providing the care that is most often determined by someone else to be provided. Suddenly, one takes on the identity of a role: they are a “COVID patient”, a “psych patient”, the “sepsis in room 3”, an “ICU nurse,” the “scrub nurse,” or the “float.”

The acute care hospital employs specifically constraining techniques to reduce social interaction with the outside world. Goffman described that reduction of social intercourse is built into the very structure of the total institution. Hospitals commonly have various layers of restrictions, increasingly intensifying based on the level of total control institution assert legally or administratively over the patients being cared for or the nurses ostensibly providing this care.

Hospitals employ security officers, or even off-duty law enforcement to guard entrances. Visitation is limited or even restricted by staff. Doors and hallways are restricted to specific personnel, with access abilities pre-programmed into employee ID badges and badge readers on doors—this ensures both that only certain people can enter and exit, and that those entrances and exits are recorded. Institution policy limits time patients are allowed outdoors or off hospital property, if permitted at all, with risk of expulsion from potentially life-necessitating resources or placement into increasingly restrictive environments should they fail to comply. Similarly, nurses may be required to stay on hospital grounds for extended periods if involved with complex cases, in instances of disaster (natural or human generated), or when they are the sole provider of a specific type of care for a particular patient. In either case it is often difficult if not impossible to function in the engaged role a person holds on the "outside," and once returning to one's normal life, the losses while in the hospital may be irrevocable and painfully lost. For nurses, this became particularly apparent during the COVID-19 pandemic, as many were forced to work long periods without respite only to be unable to return to homes and families because of the risk of transmission. Many reported caring for patients who were even more isolated as the nurse might be the only other person with whom they had even brief contact in a day—indeed, some patients died under these circumstances, deprived of family and other social supports (Walton, Murray, & Christian, 2020). Both patients and nurses are obliged to play their designated role within the hospital walls. While for some, re-establishment of roles may be possible once released from the hospital, some may suffer irrevocable losses through missed time receiving education, advancing one's career, or raising children.

Goffman described that upon admission to a total institution, the individual is stripped of his usual appearance and thus suffers personal defacement (Goffman, 1968, p. 20). The patient

and the nurse are both, as Goffman described, “trimmed and programmed” (Goffman, 1968, p. 16); the person becomes an object existing to serve the establishment through processes like providing insurance information, clocking in and out, undergoing various assessments of health-related characteristics, providing inventory of belongings, and the like. Upon admittance to the hospital institution, one of the first actions is the shedding of “outside” clothing: patients are placed in a gown that opens in the back and ties around the neck, while nurses may be required to don specific uniforms or protective equipment. The belongings, or artefacts of one’s identity, are removed and sent to a safe or placed in a locker for “safe keeping”. For both patients and nurses, those affiliated with psychiatric care must often relinquish *all* artefacts, including phones and phone cords, under the premises of safety. The patient is assigned a number, and a wristband is affixed, with a barcode that is scanned which provides the staff with information deemed pertinent to the function(ing) of the hospital. The nurse activates a locator badge or pager, ensuring that they can be monitored and contacted throughout the workday according to the needs of the institution. From this point most actions are monitored, including those normally taking place with some degree of privacy, including eating and using the bathroom. Goffman described that movements and postures, or positionings are in fact facets of mortification of self, and this is seen in the restricted physical movement imposed on both patients and nurses. There are a series of degrading postures and patterns of deference required of patients justified on the grounds of necessary medical and nursing interventions, or, safety (Goodman, 2017). Patients are generally required to lie in bed, unless supervised ambulation has been approved. For patients not compliant with staying in bed, bed alarms are activated, and the patient may be ultimately restrained to the bed. Ironically, nurses may face similar degradations when ordered to initiate treatments they feel are inappropriate, required to stay beyond regular working hours to “help,”

or instructed to turn over personal protective equipment to providers deemed hierarchically superior.

Goffman also described that in total institutions, the passage of information to inmates is restricted. This is no different in the hospital setting. Multidisciplinary rounds are most often conducted outside of the patient's room, in which a team of medical professionals discusses the patient's case and plan, without patient input. In some cases, only physicians are included in these discussions—despite the fact that the majority of care activities will be performed by nurses. In a small fraction of cases, the physician actually informs the patient directly of a select few pieces of information regarding the plan for the day. Despite the generally accepted premise that meaningful partnership with patients and nurses enhances patient care delivery and outcomes, investigation has demonstrated that in fact very few interactions elicit patient involvement in decisions about their care, and nurses have little autonomy in directing that care (Paola Galbany-Estragués & Dolors Comas-d'Argemir, 2017; Redley et al., 2019). Additionally, a patient is not immediately privy to their own medical record and must go through a process of bureaucratic check boxes and permissions to access the records, usually only available after the course of hospitalization is complete. While 'open' medical records are becoming of increasing popularity there are ample regulations on patient access to health information. A recent cross-sectional study of US hospitals found that there was widespread noncompliance with state and federal regulation for formats and release of medical records, inhibiting timely access to one's personal health information (Lye et al., 2018).

A Formally Administered Way of Life

Persons who engage with the institution of the hospital, especially over extended time period—whether as patient or nurse, must ultimately succumb to the institutionally managed

spheres of activity that generally have clear boundaries when taking place on the “outside.” This amalgam of social spheres is often surveilled in a panopticon-like fashion, which facilitates a self-regulation of behavior for the purposes of supporting the operations of the organization (Wade, 2016). Goffman’s observations on how people behave differently in face-to-face private interactions than when being monitored laid the groundwork for Michel Foucault’s work on panopticism (Manokha, 2018). Panoptic surveillance is a means of exertion of power and control, and may in fact cause someone to exercise the sovereign’s power over themselves without any direct coercion (Foucault, 1975). Beyond the walls of the institution and the panoptic gaze, normal daily activities like eating, sleeping, toileting, and leisure, are done with some recognizable degree of autonomy, privacy, and in reasonably different locations. In the hospital, life is experienced and monitored and controlled in the same location by the same central authority for the purposes of efficiency, productivity, and safety—applicable to both patients and nurses. Usual activities of daily life are conducted in the presence of other people and daily schedules and activities are often entirely pre-determined for the efficiency and productivity of the organization. Radiology testing, procedures, mealtimes, periods of rest, quiet time, activity time, and transport from one area of the hospital to the other, are all pre-determined and under varying degrees of supervision. Internet access can be limited, preventing patients from communicating with family or friends, and preventing nurses from accessing some kinds of references and resources. Bed alarms notify staff of patients moving in or out of bed, remote video surveillance technology tracks both staff and patient movement, and the practice of placing tracking devices on patient wrist bands as well as on staff identification has become exceedingly commonplace (Bazo et al., 2021; Kanani & Padole, 2020).

In a total institution, there is an echelon of surveillance, where even those doing the supervision are themselves being observed. The mechanism of surveillance dictates the structure and processes of the institution in powerful ways. Controlling workflow and physical spaces that a nurse occupies is critical to maintaining surveillance and productivity. De-centralized nurses' stations have become increasingly popular with hospital renovation and new construction, ostensibly to decrease walking and increase direct patient observation (Design, 2017). An additive effect, however is the decreasing of nurse interactions, teamwork, and information sharing, causing feelings of isolation (Fay, Cai, & Real, 2019).

Further, both the nurses and patient are directed by and managed within a powerful modern influence of the panoptic mechanism of control: the electronic health record and the many technological modalities that monitor the nurse's performance and productivity as well as the patient's compliance with treatments. The electronic health record requires consistent inputs and outputs that the nurse must manage: a feeding of data which the nurse mines and surveils from the patient, data that is then digested and output as tasks the nurse must perform by certain times. All of this becomes, "…discrete mineable data points that go on a construct map of the patient experience… and an audit trail for nurses' behaviors, surveillance in absentia… a proxy governing forces that are not necessarily present" (Dillard-Wright, 2019, pp. 1-2). The ever-present and omnipotent panoptic governing nurse practice can also be found in the locating and pedometric technologies that monitor nurses' steps, tracks and trends amount of time spent in patient rooms, and even dictates the amount of resources units receive based on acuity calculators (Miclo, 2015). The nurse and patient alike are under the continuous sovereign gaze, serving the productive drive of the institution.

A total institution disrupts the autonomous actions of the individual, and degrades the perception that one has self-determination, autonomy, and/or freedom of action. This results in a feeling of impaired agency, the ultimate result of efforts to manage daily processes of large numbers of people within one setting as productively as possible, while expending the fewest possible resources. A nurse, assigned more duties and responsibilities than may be humanly possible to accomplish by a mechanistic health system (Park, Hanchett, & Ma, 2018), needs to ensure that every patient is in their place, non-disruptive of the milieu or the tasks at hand, ready and willing to receive interventions as prescribed. If this is not accomplished, the nurse may face recriminations, poor performance reports, and ultimately dismissal. To preserve the sense of self, the nurses is thus forced to exert authority and even coercion on patients.

Ironically, at the same time, a patient's means of maintaining agency may be seen in such antagonistic behavior as "acting out" and becoming what is often described as a "difficult" or "non-compliant" patient (Dudzisnki, 2017). This may be seen in patients refusing to stay in bed, demanding different food, yelling, refusing to stay in their room, refusing to take certain medications, refusal to participate in therapies—a whole host of behaviors frequently assessed as "noncompliance" with treatment (Scarlett & Young, 2016). A person's autonomy is further degraded when such behaviors are used as evidence in support of assertions of psychiatric instability, impaired decision-making capacity and such interventions, and punishments, such as restraints, seclusion, or sedation are used (Beysard, Yersin, & Carron, 2018). Goffman (1968, p. 41) described that in a total institution, compliance must appear to be absolute, or punishment may be swift. In 1995, the North American Nursing Diagnosis Association recognized non-compliance as a nursing diagnosis, indicating that a patient's aversion to a prescribed plan of care and method of care delivery is to be identified, measured, and resolved in order that the nurse has adequately

performed their job (Russell, Daly, Hughes, & Hoog Co, 2003, p. 283). This is despite the fact that more recent research has demonstrated that such labels correspond with patients not receiving the same level of support or care as those assessed to be ‘compliant’, thereby causing harm (Groth, 2017). This ‘diagnosis’ is highly subjective, and arguably wrought with stigmatizing views of who is and who is not deserving of personal agency. This potentially dangerous assertion of control illustrates the inherent power structures at play.

Conclusion

This paper has provided a description of Goffman’s total institution, as well as tangible examples of the ways in which modern acute care hospitals embody and operationalize totalizing practices. We describe some of the many mechanisms by which mortification of self is operationalized behind contemporary hospital walls, as well as the formally administered ways of life for both patients and health care workers that ultimately strips them of autonomous authentic human connectedness while operating under the panoptic capitalist medical gaze. As we move toward a more just healthcare system, it is critical that we both make visible examine the ways in which these demonstrated totalizing practices disrupt the agency of both patients and health care providers.

Chapter 3

"So There. I Won.": The Struggle for Power Between Caring and Carceral Institutions

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“So There. I Won.”: The Struggle for Power Between Caring and Carceral Institutions

Introduction

Rates of incarceration in the United States (U.S.) are higher than anywhere else in the world, at 754 per 100,000 of the national population. The U.S. represents about 4.4 percent of the world's total population, but houses around 24.7 percent of the world's prisoners (Glaze & Bonczar, 2006). In 2018, there were 2.3 million people in custody, and an additional 4.5 million on probation or parole; thus, approximately 1 out of every 32 Americans is under some degree of criminal justice control (Trusts, 2018). Over the last several decades, incarceration rates have increased by over 500%, despite crime rates decreasing overall (Shapiro, 2019). After the passing of the Anti-Drug Abuse Act of 1986, the incarcerated population rose from approximately 300,000 to over two million over a 20 year period (Glaze & Bonczar, 2006). In a country where mass incarceration is pervasive, particularly for people of color, patients in custody are receiving an increasing amount of medical care in hospital settings; in fact, hospital care accounts for about 20 percent of prison healthcare spending (Jeremy Travis & Western, 2014).

Racial Disparities, Vulnerable Populations, and Migrant Detainees

Incarcerated patients are an identified vulnerable population according to the Centers for Disease Control and Prevention (Prevention, 2014). Given the disproportionate rates at which people of color, people living with mental illness, and migrants are detained and incarcerated, it is critical to investigate the forces that influence or worsen disparities in care. Understanding how forces of control such as law enforcement presence influences the care that nurses can and cannot provide can inform approaches to shielding vulnerable patients from detrimental effects in this encounter. Racial disparities in the U.S. incarcerated population are striking. Black men are incarcerated at more than five times the rate of white men, and Black women are incarcerated at

nearly two times the rate of white women. (NAACP, 2019). While research shows that Black and white Americans use illicit drugs at fairly equal rates, drug charges are six times more likely to result in imprisonment for Black Americans (Goshin, Colbert, & Cloyes, 2015). In fact, if Black Americans were imprisoned at the same rate as white Americans, the incarcerated population would decrease by over 40 percent (NAACP, 2019). Significant to San Diego, California the border city in which this study took place, in a 2019 interview with U.S. Customs and Border Protection Commissioner McAleenan, he discussed that 38,591 migrants were taken into custody at the San Diego US border in 2018. In the first six months of 2019, an average of 55 people per day in San Diego border patrol custody were sent for acute care medical treatment, requiring 5,700 supervised hospital shifts in San Diego County alone (Stickney, 2019). Nationally, there have been 153,000 monitored hospital hours of care for detained immigrants(Gomez, 2019) this year. As our country experiences a striking and continued increase in law enforcement oversight over the population, particularly people of color in the U.S., we can expect that interaction with law enforcement may be increasingly common during the provision of nursing care.

Importantly, there is a gap in understanding how law enforcement practices and professional cultures affect a nurse's ability to provide safe, sound, and ethical care. Moreover, little is known about law enforcement's understanding of their own roles and expectations in acute care settings, and their perspectives on interacting with health care providers. In San Diego County, registered nurses (RNs) may interface with any or all of 15 local, state, and federal law enforcement agencies. This study sought to understand the tensions inherent in this socio-ecological dynamic, how it affects nurses, and influences delivery of nursing and other medical care to the vulnerable population of patients in custody in acute care settings. Further, we aimed to get a better

understanding of law enforcement officers' perspectives regarding their interactions with RNs. There is a paucity of research on both of these.

Purpose

The primary purpose of this study was to give voice to the lived experiences of nurses and law enforcement officers who interact in the hospital setting, while gaining understanding of their individual perspectives and unique experiences, as well as of their interpretations of these experiences. Caring for people accused and convicted of crimes is a required duty for many acute care nurses. While law enforcement and custodial institutions may operate with rigid and clear guidelines, adherence to these guidelines is often challenging in acute care settings where nursing care is provided. Law enforcement's attempts to keep the incarcerated patient under strict surveillance and control can interfere with and impede nursing care delivery.

Methods

Qualitative research is particularly well-suited to answer research questions aligned with nursing's iterative, contextual, and hermeneutical nature, and allow for exploration of complexities inherent to the experience of caring for patients in complex settings. This study utilized interpretative phenomenological analysis as a primary methodological approach to understanding the lived experience of interactions between nurses and law enforcement officers, as well as to offer the opportunity for participants to express their interpretations of these experiences.

Research Design

The lived experiences of nurses and law enforcement were explored qualitatively using interpretative phenomenological analysis (IPA). IPA allows the investigator to document a detailed description of the events and an opportunity for exploration of the personal processes related to the events (Denzin & Lincoln, 2003). The IPA steps as delineated by Smith et al.

include (1) “immersing oneself in the original data” by listening intently to the audio recording and reading and re-reading each transcript (p. 82); (2) “examining semantic content and language” of the data to identify and note content of interest (p. 83) (3) “analyzing exploratory comments” from the first analysis to identify and develop emergent themes within the data(p. 91), (4) discover for connections across emergent themes by utilizing abstraction, polarization, contextualization, numeration, and function (pp. 96-98); (5) moving to the next data set to repeat the process; and finally (6) looking for patterns across cases.

The methodology was selected based upon the nature of the research problem, the researcher’s personal experiences, known body of literature on the phenomenon, and the study audience (Lincoln & Lynham, 2011). Interpretative Phenomenological Analysis (IPA) allows for both inductive and descriptive analyses, through which we aim to understand the cognitive and subjective perspective of nurses’ and law enforcement officers’ interactions, and the effect that these have on their lived experiences in the acute care setting (van Manen, 1997). The goal of IPA is to understand human beings’ perceptions of the world and to make sense of their experiences, “by looking in detail at how individuals talk about the stressful situations they face, and how they deal with them, and by close consideration of the meanings they attach to them” (Smith et al., 2009, p. 270). Through IPA, the researcher engages in the “double hermeneutic” of seeking meaning from the participants’ efforts to make sense of experience(Smith et al., 2009, p. 3). In this study, IPA allowed for both inductive and descriptive analyses, to spark understanding of both the cognitive and subjective perspective of participants’ interactions, and the effect that these have on their lived experiences in the acute care setting (van Manen, 1997). In this study IPA elucidated valuable insights into the participants’ experience of interactions, moral distress and injury,

perceptions of role identities and expectations, and how forced interaction between nurses and correction officers affects these.

IPA employs purposive sampling methods, of which the power and logic "lie in selecting information-rich cases for in-depth study. Information rich cases are those in which one can learn a great deal about issues of central importance to the purpose of the inquiry. Using information-rich cases yields insights and in-depth understanding" (Patton, 2015, pp. 264-265). Specific to phenomenology, sampling is "choosing informants" (Cohen, Kahn, & Steeves, 2000, p. 45). In-depth semi-structured and non-directed interviews were the medium of data collection in order to (1) gain access to the phenomenon of caring for an acutely ill or injured patient who is under the custody and control of law enforcement; (2) "give voice to" (Larkin, Watts, & Clifton, 2006) the intimate experiential understanding and elaboration of this experience through words and bodily gestures; and (3) through phenomenological interpretation, to understand the subjective processes and perceptions of this experience, a feature not otherwise developed in the literature.

Research Question

The study sought understanding of the lived experience of registered nurses and law enforcement officers when interacting with one another in the hospital setting; particularly the ways they perceive their role and responsibilities in this dynamic, their experiences with self-efficacy and moral injury, their perceptions of power, and ways in which their professional standards are affected.

Recruitment and Sample

The study was advertised on social media, via flyers in various hospital departments, and by the provision of study information sheets to nursing department leaders and members of law enforcement working in the hospital. Study information was provided to all participants prior to

scheduling the first interview. Potential and actual participants were also encouraged to share the study information sheet with their colleagues in both fields. Registered nurses volunteered to participate very quickly in response to social media posts, however law enforcement officers were generally directly referred by other law enforcement participants.

A total of 10 registered nurses, and 9 law enforcement officers participated in the study. Due to the perceived sensitive nature of the interviews and requests for anonymity, not all participants provided complete demographic data. The available participant demographics and summary can be found in Appendix C. Prior to the initiation of any data collection, it was verified that the study was exempted from oversight by the University of California, Irvine IRB. To protect anonymity, all data were de-identified and participants were assigned a pseudonym. All data were password protected and stored securely. All study participants received $50 at the conclusion of the interview, which lasted approximately one hour.

Procedures and Data Collection

This study employed semi- structured interviews which provided critical and detailed information to better understand the phenomenon and achieve the research aims. The PI interviewed 10 registered nurses and 9 law enforcement officers. Of note, a 10th law enforcement officer was scheduled for interview but cancelled the session, citing the Derrick Chauvin trial as a reason to not participate. An additional four law enforcement officers also signed up to participate but did not log on for their interviews. Each participant was invited to a one-on-one semi-structured interview via Zoom. Participants were asked to share their experiences working with nurses or law enforcement in the hospital, and to describe the types of challenges, positive working relationships, and any reflections on their interactions. The interviews were audio recorded, and the PI kept field notes to note particular expressions or behaviors. The PI also

conducted member checking to clarify and validate interpretations, and to cross-check responses with other participants for either confirmation or difference. The interviews were transcribed, then coded and analyzed. Three nurse participants also sent follow up emails with additional thoughts and reflections in written form following the interview, and these were included with the data for analysis.

Data Analysis

In the initial stage of data analysis, the PI listened to the audio recording several times throughout the transcription process then read and re-read the transcript in its entirety. After initial notes and reflections, the PI imported all transcripts into ATLAS.ti ®. Extended field notes were added on statements or ideas that stood out. Additional notes and memos captured intensity in tone of voice, emotions, and any additional questions, thoughts, or unexpected or surprising elements emerging from each transcript. Transcripts were then coded paying particular attention to language and specific words used with frequency, the style of language, and the mood and intensity of the participant's communication. Throughout this process to remain open to surprising emerging ideas the PI also made careful note of what was or was not initially coded and re-reviewed the transcripts iteratively for content in areas not initially identified. Through the use of quotation managers and visual network charts, the PI identified codes which were most prevalent for individual participants and across data sources. In following Smith et al.'s methodology, all codes were derived through in depth and repeated review of each transcript. This process was then followed by analyzing across all data sets to identify both similarities and differences in codes.

While it is obvious that statistical generalizability is not relevant for a qualitative study, analytical generalizability was sought. Analytical generalization "involves a reasoned judgement

about the extent to which the findings from one study can be used as a guide to what might occur in another situation" (Kvale, 1994, p. 233). Analysis followed a cycle both iterative and inductive using coding. This process begins with analyzing the experiences, understanding, and concern of the participants by reviewing the data line-by-line. Emergent themes are then identified, making not of convergence and divergence as well as the commonalities (Smith et al., 2009). The thoughts, emotions, and feelings are critical components of how people describe their lived experiences. Therefore, emotion coding was especially appropriate in this study that sought to explore interpersonal and intrapersonal experiences and actions and provided insights into the study participants' worldviews and perspectives (Miles, 2014, p. 75).

Results

Overwhelmingly, the participants described a contentious dynamic between nurses and law enforcement in the hospital, wrought with argument, stress, and a sense of coming from "different worlds". These worlds were often described as colliding or crashing together. Although most participants voiced a wish to come to a compromise or find "common ground" between nurses and law enforcement in patient care settings, few had experienced situations in which commonality was reached. An overarching theme found throughout the data is the effort to maintain power and control. Both groups argued for the imperative of their own power and control of the patient as well as the environment across multiple domains. The ensuing struggle resulted in a variety of ways in which both nurses and law enforcement attempted to maintain authority and control, often going back and forth until someone conceded. Success was often determined not by compromise, but by whomever had the last word--as one officer poignantly ended a description of a tense argument with a nurse: "So there. I won."

This paper reports the most significant operations of the struggle for power found in the domains of physical and relational operations of control: shackles and restraints, assault, the withholding of information, unfavorable behavior, and interfering.

Physical Operations of Control

The tangible manifestations of physical exertions of power were often the first provided and most emotionally impactful examples discussed by the participants. The following sections explore sub-categories within this domain.

Shackles and Restraints

Nurses and law enforcement alike provided recurrent expressions of shackles as a locus of disagreement and escalation of conflict, and all participants identified shackling and restraint of the patient as a frequent point of contention. There was an intense awareness of the shackles, and of who determined when and how the patient was shackled. For nurse participants, the issue was not necessarily that the patient was shackled, but more the nurses' need to be the party determining how, when, why, and where the patient was restrained:

> I want this patient out of their shackles, and to me, that is a non-negotiable for me, 'cause I don't wanna see a patient in a four-point restraint, a four-point situation where they can't move, they can't do anything, and you will argue. If this person needs to be restrained, I will be the one restraining them.

To the nurses, restraining each limb is one of the most restrictive methods of restraint, meaning that a patient cannot turn, sit, walk, or move their limbs at all. For the law enforcement officers, the shackles were presented as a necessary safety tool to prevent a patient from escape or from hurting people. Many of the law enforcement officers felt that the nurses arguing about the

shackles was for no reason other than to give the officers a hard time, and that shackles were important for the safety of all involved as well as for their own job performance:

> They [nurses] would want us to like, “Oh, you need to unshackle him, or unshackle her, her legs.” “Well, do you need to use their legs or anything?” “Well no...”. Well we can't unshackle them as long as they're in our custody, we have to have them shackled, but we would always have an issue with that with some of the nurses.

Some law enforcement participants also cited interaction around shackles as a marker of what constituted “good” relationships with nurses in certain settings:

> The nurses understand why we're bringing this person to the hospital, if they're in cuffs, they understand that they're in cuffs, they don't try to overtake police actions when they're interacting with the arrestees, they're very professional and they respect that this person is in custody, we can't just have them freely roaming without handcuffs or unattended.

Nurses also mentioned safety related to shackles, but most often because of the physical harm the shackles could cause the patient. For the nurses, breakdown in skin integrity was a point of contention, as well as shackling preventing the patient from ambulating and participating in therapies. The nurses acknowledged that there are situations in which the patient needed to be restrained for safety but felt that the nurse should make that decision. As one nurse said:

> We kinda gotta step in like, simply as like, “that handcuff is too tight. We just see it breaking through their skin, can you loosen it?” "No." “But why?” "Well, can you take it so we can put a Mepilex® under it?" And then they get irritated about that 'cause we're simply trying to make sure the patient's safe and taken care of... So, it's a tough one.

A final issue arose in the conflict between the nurses’ perceptions of the shackles and law enforcement’s handling of the shackling as hindering their nursing care. Many saw the shackles

as an example of why they felt that many patients in custody did not receive care to the same level as patients not in custody. While the law officers acknowledged knowing that nurses felt this way, they disagreed:

> The nursing staff feels that they cannot treat that patient if the patient is shackled to the bed, and there's discussions that I've had with nursing staff and I explain to them without divulging the criminal background that that individual has, I just tell them I cannot for safety reasons, not chain them up to the bed, and I've had arguments with nursing staff.

Another law enforcement officer said that, with regard to the patient, they needed to "Handcuff him before he gets out, handcuff him to the bed, and when the nurse is like, 'Hey, why are you so on top of this guy?' I'm like, 'Well, he did a bad thing, and I wanna make sure that we're all safe.'"

Threat or Incidence of Violence

Many participants referenced either a sense of threat or experiences of actual violence in the interactions among nurse, law enforcement officer, and patient in custody. Two significant dynamics that emerged from these descriptions related to weaponry and assault.

They're the One with a Gun. Nurses described situations in which they felt a need to assert control or question behaviors or decisions of law enforcement, but because the officers were in possession of a weapon, they second guessed themselves, or kept quiet. Several of the nurses felt that because the officer had a weapon, that officer ultimately had purview to decide to do whatever they felt necessary. One nurse described this vividly: "I don't know, they're sitting there with a gun, and they can still arrest me if they want to. He's a cop. He can do whatever he wants to whoever he wants. That's, really what's going on here." Another suggested feeling threatened in such situations: "The officer is going to win. He's the one sitting there with a gun. .... And… they can be a little bit intimidating."

Several nurses also provided examples of physical exertions of power using weapons in the hospital setting. One nurse described a striking incident following what she described as multiple days of harassing phone calls from law enforcement. The callers demanded information on a patient, and ultimately multiple officers entered the hospital unit with guns and physically pulled the patient out of the department before they were cleared for discharge. Another reported:

> …there was an incident where the patient was cuffed appropriately, but his chains were longer, and he was actually able to thrash them around and create sparks, which then prompted the officer to actually shoot him...in the head. The doctor and I were able to get over there…, the doctor got an airway in and we were able to keep his heart beating and get him back to the emergency department where he later passed of a brain herniation from this gunshot wound, but I'll never forget….

None of the officers mentioned their weapons as a mechanism of asserting control over the nurses, however one officer spent a large portion of the interview describing the importance of always having someone with a gun with them in the hospital. The officer highlighted the sense that an officer is not safe without either having a weapon or having someone with a weapon present to specifically protect and watch over the officer.

They Beat Him Up. Four nurses described witnessing acts of physical violence by law enforcement as means to gain control over a patient. These nurses described witnessing law enforcement use physical force in ways that they deemed unethical, unnecessary, and even malicious, and several paralleled what they witnessed in the hospital to police brutality in the community. These moments of physical exertions of power were often described as pivotal moments for the nurses—they had ruminated on the incident, some for many years, and felt it vastly shaped their interactions and perceptions of law enforcement going forward. The nurses

voiced feeling that they should have intervened or “advocated harder”, and said that what they had witnessed caused lasting anxiety:

> I remember I had a patient, he loved the staff, but when he had to interact with the guards, it was very violent behavior, and I remember they actually closed the door and… suffocated the patient with pillows, and I had to stop them and be like, "Hey, that is inappropriate, and that it's not what can happen... Or what we do here." …. I couldn't believe what I was seeing and obviously in their environment, I'm sure those kind of things occurred with the very violent restraining type of mechanisms they use, but I had …to stop them... I was like, “You just can't do that! …he is the patient here, you can't do that to him!”

Relational Power

While physical exertions of control offered powerful and visible evidence of power, other *perceived* exertions of control or power came in the way of more relational exchanges. These examples emerge in reflections on the other professionals’ behaviors.

Interfering. Several nurses expressed experiences with law enforcement attempts to interfere with the care they would usually provide, with potential implications for the patient. Most examples of interference were in law enforcement not allowing nurses to speak to the patient, commenting on or dictating which interventions the nurses could or could not provide, and failure to remove shackles. One nurse related, “I did have a law enforcement agent telling me I was doing my job incorrectly and tried to fire me from a patient assignment…. I touched the patient's hand when they were upset, which is therapeutic touch, which we do all of the time, and was told that I was being inappropriate, and I needed a new assignment.” Another described interference thus:

> I've had officers say, “you shouldn't talk to them nicely”. Or if they are in shackled on every extremity, when I asked to have that removed…so we can provide that... same level of care that we need to provide to our patients for protecting breakdown of their skin or allowing them to ambulate appropriately…. It depends on the level of participation that officer is willing to give to that patient, and sometimes it makes it hard when they're not willing to provide that level…. …that definitely becomes very disruptive to that patient in regard to their recovery, and so advocating…can be challenging….

When asked about nurses' perception that there was interference with patient care, some officers acknowledged that this does occur. One noted, “I have seen officers give nurses a hard time 'cause they wouldn't do this, and they wouldn't do that or whatever…” Another said:

> I feel that nurse may feel that I'm invading her work environment and that [they're] unable to do [their] duties…. If they give us bad looks or don't acknowledge us…our interaction is not gonna be a great one. And we can actually make it difficult for them as well, …and there's agents that will say something to the medical staff, if things don't go their way.

Similarly, the nurses acknowledged that their reluctance to give officers patient-related information was perceived as obstruction and interference:

> I know in their perspective…. the cop was frustrated 'cause he felt like we…were purposefully not letting out…samples or whatever, I feel like he felt we were doing it on purpose…. He's like, “Oh, you're gonna make us do it the hard way.” And it's like, no, it's the legal way.... I think they can see it as purposely putting obstacles in the way, but I like to hope that most of them understand that we're not doing it... out of spite.

Some officers also shared that being asked to wait while the patient was being cared for sometimes seemed unreasonable and suggested that they were being purposefully ignored. The officers suggested that a positive relationship with a nurse was a result of compliance with officer requests, no interference in their work, and an ultimate respect that the person is in *their* custody. As one said, “I don't know what it is, but different hospitals do different things, so what we experience a lot is that when we go to the hospital and we have a prisoner, then they wanna try to tell us pretty much how to do our jobs like, “Oh well, you need to do this”, [and] like, No.” Another officer described what happened when officers did not feel their duties were given priority: “I've heard horror stories where they make some nurses cry, but, you know, most of those stories, I hear the background behind it, and they deserve it because they weren't very friendly with us… not acknowledging us, not respecting us and not telling us what they want before it escalates.”

Withholding Information

The withholding of information also reflected operationalization of power and presented a source of conflict. Both nurses and officers described trying to manipulate the flow of information. Law enforcement often viewed the withholding of information as a power play, but nurses felt that it was an act of advocating for the patient, being the patient’s voice, or upholding patient rights. The nurses described not only withholding information from officers, but even actively preventing patients from giving information. One nurse described such a situation:

> I often have law enforcement officers that are there to question patients and retrieve information. Often, my patients are under the influence of drugs and alcohol and often do not understand their rights…. And then often their medical condition is influencing their

> participation with the officers around as well, so [it is] not only my caring for the patients, but I'm also interacting with the officers….

Another invoked the fear that the officers were seeking information with malicious or manipulative intent. Many nurses felt that law enforcement was trying to get details in order to cover up harm caused to the patient by law enforcement, or to use against the patient once they were back in the carceral setting:

> We'll bring our own security up here…, so we can make sure that we are doing the best job we possibly can to protect that patient, to make sure that that the officer is not intentionally or unintentionally incriminating [a] patient, and… they become very confrontational…, when all we're trying to do is advocate for our patients, and they will say we're obstructing justice, they'll say that we are interfering with their investigation.

Similarly, law enforcement also withheld information that nurses deemed important, including information on the mechanisms of injury, previous care provided to the patient, and next of kin. One nurse described a tense conflict she experienced when attempting to gather information on the family of a brain-dead patient in ICE custody. When the ICE agents refused to answer any questions, the nurse contacted the nurse at the detention facility in hopes of obtaining more information on both what happened to the patient, and how to reach family members. Upon finding out that the nurse contacted the facility, the ICE agents became irate and told her she was not to talk to anyone.

The most contentious and high stakes dialogue on withholding information surrounded law enforcement requesting or requiring nurses to provide information on the discharge of a patient so that the patient could be arrested. Law enforcement officers reported that not receiving requested information from nurses was a major point of contention and alluded to tactics used to

elicit more information. One officer highlighted the feeling that nurses' actions were preventing the officers from doing their jobs and that they had to be forceful in response: "I wouldn't exactly say it's bullying…they pretty much say, "Hey listen, you're impeding our investigation," which is what they're doing when they don't give us the information that we need."

The nurses expressed feeling put in the middle, and that their refusal to inform law enforcement of a discharge resulted in escalated behavior from the officers. One nurse firmly stated:

> I will not disclose information, I will not participate in an arrest. Those are not within my scope… I'm happy to participate in things that you know, I need to have the shackle on the bed sure, I understand, but that if you're asking me to elicit information, then that's a lot different interaction that I'm not willing to participate in.

Another expressed internal conflict in such a situation:

> There's a lot of times when we have struggles with the custody where they.... They'll not wanna sit on them and so they'll release them or "It's okay, well, we're gonna leave them", There's that moral distress, where like, as a citizen, I would like you to have this person in custody... absolutely, but as a nurse, that's not within my scope, it's not my duty…. I'm not the police.

Interestingly, law enforcement reported that there is variation among hospitals as to providing information, and that they view it as a professional courtesy:

> We have the ability to arrest and unarrest in our department so we can unarrest them and then ask the hospital, "Hey, let us know when he's leaving".... Some of the hospitals will do that…and we'll get a call, so…then we can come over and get them.... Some refused to do that. So then there's all this stuff we have to do... We have to get a warrant for their

arrests and all this other stuff, and…that lack of cooperation is difficult to manage…. And it's very frustrating. Why couldn't they just call? Right? Why can't they just call?

Discussion

Despite the increasing number of persons detained, there is a paucity of literature on the interactions between nurses and law enforcement in the hospital. This research was intended to make visible a little-known but oft experienced phenomenon, and to fill a gap in the literature on the ways that biopolitical institutional forces are operationalized at the bedside of some of the most marginalized and vulnerable patients in our communities. Grounded and guided by feminist theory, biopolitical theories and philosophies as written by Foucault, Agamben, and Goffman, the study utilized interpretative phenomenological analysis (IPA) to cultivate an in-depth understanding of the phenomenon through the eyes and experiences of both registered nurses and law enforcement officers.

The works of Michel Foucault and Erving Goffman are seminal in the exploration of experiences of the delivery of (or limitations to) health care in a setting of carceral influence. Foucault offers this study nuanced philosophy on bodies and lived experience in biopolitical power structures, and Goffman's work both exposed and explored "tensions and contradictions between therapeutic demands of care and the imperatives of social control" (Jacob, Holmes, & Rioux, 2019, p. 1012); a dynamic that saturates the data of this study. The summation of themes that emerged were operations of, manifestations of, or reactions to an attempt from two parties, self reportedly of "different worlds", to maintain power and control. Both parties did indicate an ascribed sense of authority and decision making within their own institutions and described a collision of two worlds; a collision that distorted the clarity in which one world began and another ended, and therefore muddied the vision of whose power reigned supreme. This "gap"

resulted in attempts to gain, or maintain, power and control of what happens to the patient, through different physical and relational exertions of power.

The Nurse Experience

The nurses described their experiences with law enforcement as generally “not positive” and cited numerous examples of overt and covert conflicts. Nurses also spoke about the ways in which “dealing” with law enforcement was just another layer to job already fraught with competing priorities and challenging to meet the demands of the patient and the institution. These nurses indicated that this dynamic is an added layer of stress that contributes to burnout and turnover, and that it is hard to recruit nurses to areas in which the law enforcement presence is prevalent.

The nurses overwhelmingly indicated that within the walls of the hospital, the nurse should be the bearer of power and hold decision making authority. The nurses voiced that they are bound through institutional policies and procedures, laws and regulations such as HIPAA, and less often, nursing ethics, to protect the patient. The most poignant focus was on protecting patient information. Nurses recognized, though, that law enforcement does not generally share the same sentiments regarding authority or respect for institutional policy, though they felt strongly that law enforcement should be required to adopt and follow the rules of the institution once they cross the threshold. The nurses shared a general sense of unease and mistrust of law enforcement, citing instances in which law enforcement seemed to operate with malicious intent and could not be trusted.

A common source of nurses’ concerns was the use of shackles or other restraints by law enforcement. Although preservation of patient autonomy is a core tenet in the nursing code of ethics (ANA, 2017), and restraints in the hospital are only to be used as a last resort (The Joint

Commission, 2021), these topics were not discussed in regards to restraints. In general, the nurses focused particularly on a need to care for the patient's skin, placing protective barriers under shackles, loosening cuffs, or moving them to a more convenient spot. This fixation on the skin is profound, as prevention of skin breakdown is a highly audited, surveilled, and regulated Nursing Sensitive Indicator, directly correlated with hospital reimbursement (Yakusheva, Lindrooth, Weiner, Spetz, & Pauly, 2015). In Goffman's descriptions of total institutions, the values, priorities, and processes dictated and surveilled are for the purpose of serving the institution, and the institution alone. The shackles are thus representative of the ways in which the detained patient serves the institution, and both how nurses and law enforcement operationalized the stringent processes and expectations defined by their respective total institutions.

Ultimately, the nurses reported a sense of impaired self-efficacy in performing their jobs, and many nurses provided examples of challenges and poor outcomes to the patients that were of particular impact. When sharing these stories, the nurses exhibited an emotional response, several crying while sharing harm caused to the patients, or a sense of failure on their part to care for, or advocate for the patient in the way they felt they should have. While most of the nurses presented the power struggle as a dichotomy of *good* and *right* (nurses) versus *dehumanizing* and *manipulative* (law enforcement), some of the nurses did opine that for many, the conflict for power was for power's sake, and that hospital operations lead us to "…question the illusion of nursing as we currently define it (as caring, as ethical, as the most trusted) while pairing it with the more nuanced realities of nursing as commodity, as extractive apparatus, as governmentality, and as complicit in white supremacist patriarchy" (Dillard-Wright, Walsh, & Brown, 2020, p. 134). Several nurses did share examples of colleagues "siding" with law enforcement because of

their own political beliefs or general negative perceptions of people in custody, but most nurses voiced a sense of moral distress or ethical dilemmas as a result of the power dynamic.

Four nurses described first-hand accounts of witnessing physical exertions of force on patients in the hospital, and these experiences were often cited as pivotal moments that greatly shaped how nurses viewed law enforcement thereafter. The nurses shared their perception that this was behavior that was acceptable in the law enforcement "environment", but not within the walls of the hospital. Indeed, a recent Department of Justice investigation of Alabama prisons found a high number of incidences of use of excessive force as a means of punishment, and secondary to inadequate supervision, failure to hold law enforcement accountable, insufficient staffing, failure to demand adherence to policy, and failure to discipline for policy violations (DOJ, 2020).

The Law Enforcement Experience

Law enforcement participants echoed a strained and challenging dynamic, and shared a strong perception that their presence was met with attitude and disrespect. Officers acknowledged that nurses felt law enforcement hindered their ability to care for the patients, but believed that often patients were faking illness or injury, and that nurses were biased because they were not as familiar with offenders as were law enforcement. Law enforcement voiced that their perception that nurses frequently presented challenges in their abilities to do their job, and that nurses have too much control in the hospital. Overall, the law enforcement officers saw nurses' behavior as an example of bias and misjudgment and an example of unfair judgement that results in emotional harm; a bias which potentially contributes to law enforcement suicide (Violanti, Owens, McCanlies, Fekedulegn, & Andrew, 2019).

Officers also indicated a perception that even when "in the nurse's house," they remain obligated to maintain strict control and surveillance under the premise of safety.

In particular, law enforcement cited having their weapons as crucial to their perception of safety and control of a situation. Previous studies have asserted guns are symbols of masculinity, and therefore power. Stange, Zeiss, & Oyster (2000) stated, "In men's hands, the gun has served a symbolic function that exceeds any practical utility. It has become the symbol par excellence of masculinity: of power, force, aggressiveness, decisiveness, deadly accuracy, cold rationality" (p. 22). Feminist scholars have asserted that firearm possession is a manifestation of hegemonic masculinity in which embody male domination and power structures (Stroud, 2012). The willingness and ability to engage in violence, particularly with weapons, is central to the concepts of masculine power (Messerschmidt & and violence. Boulder, 2000), and actionably using weapons is a mechanism of showing the one is in control and not afraid (Kimmel, 1996).

Synthesis

Agamben's state of exception is a powerful theoretical frame by which the law and violence may be analyzed. All of the physical manifestations of control brought forth in the data are cogent examples of the state of the state of exception operationalized in this biopolitical space. The "state of exception" is the right of the Sovereign to suspend the rule of law, or to act in extralegal capacity. Nurses and law enforcement described the ways in which they both allowed and perpetuated biopolitical and governmental forces extralegally, providing examples of the unwitting affirmation of power and totalization that occurs even in "caring" institutions (Bargu, 2014). However, we see in the reflections provided by both nurses and law enforcement small examples of resistance, and if not resistance, examples of reflection and distress that occur as the participants made sense of the violence occurring. While Agamben's work magnifies the

violence's reach, the examples of the participants provide specifications of the state of exception's dynamics and logics, and bring to light the nuanced daily actions and practices that sustain it (Valdez, Coleman, & Akbar, 2020).

While the nurses expressed shock at the exertions of physical power they witnessed, they also acknowledged that they knew this type of behavior and mechanism control was commonplace outside the walls of the hospital. What they experienced was Foucault's descriptions of the ways in which carceral punishment are "diffused through society…The prison is only one small part of a highly articulate, mutually reinforcing carceral continuum extending across society in which all of us are implicated, and not only as captives and victims" (Foucault, 1975, p. 60).

Relatedly, nurses were concerned about the manipulation of patient consent. The doctrine of consent has underpinnings in the guiding ethical principles for nurses, in which individuals have a right to self-determination, that is, to make decisions about their lives without interference from others requires respect for patients as self-determining choosers (ANA, 2017). Because informed consent serves a moral purpose to protect patients from harm, nurses have a stringent moral obligation to uphold consent processes (Johnstone, 2011). From this dynamic also comes a discussion of knowledge and power. Similar to Goffman's writings on total institutions, British sociologist Basil Bernstein examined the power dynamics of knowledge and information sharing, especially in strongly bounded and hierarchical institutions. His work emphasized the importance of the control of information and how it works to perpetuate dominant value systems within an institution (Atkinson, 2015). If both hospital and carceral systems are considered total institutions the passage of information, especially the staff's plans for the inmates/ patients, is highly restricted (Goffman, 1968). Much of the information requested centered around medical

staff's plans to discharge the patient for the purpose of arrest. Examples were also provided in which law enforcement was unwilling to provide information to the nurses on the details of the happenings with the patient prior to entering the hospital. Of significance, in a total institution the inmate/ patient is excluded from knowledge of decisions regarding their fate. This dynamic was illustrated by the participants in their discussions of planning arrest upon discharge, or law enforcement attempting to restrict nurses from speaking with the patient. From this dynamic also comes a discussion of knowledge and power. Both parties identified the power of withholding knowledge. There were multiple examples of concerted efforts to withhold information deemed critical to the other party's achievement of their goal, whether it be the information to understand the source of illness, or to identify a suspect and place them in custody. These are strong examples of the power and authority given to the knowledge holder when information is compartmentalized and kept secure (Goodman, 2017).

The nurses professed a sense of suspicion and mistrust with what law enforcement would do with information they felt should be protected, and nurse's unwillingness to provide information was a major source resentment for the officers. A potential explanation to the nurses' perception that police cannot be trusted may be found in procedural justice theory (Jackson, Huq, Bradford, & Tyler, 2013). This theory suggests that the prescribed legitimacy is a result of judgements of fairness, and that ample empirical evidence demonstrates that if a person believes that police are fair, decent, and neutral, a sense of legitimacy to the organization and the institution is granted. The theory suggests that people must see police act in a just manner and not regularly and repeatedly operate outside the bounds of acceptable norms of fair treatment. If this overstepping occurs, legitimacy may be severely undermined (Bradford, Milani, & Jackson, 2017). The tangible ways in which nurses experienced interference in delivery of care are of

particular importance and consideration for health care providers. Independence in clinical care has been cited as essential to adequate health care, especially in settings in which the relationship between a patient and their care giver is not founded in freedom of choice (Pont et al., 2018). If it is found that these experiences are pervasive, concerns about inequity in care and unfavorable outcomes for already marginalized and vulnerable populations become of grave concern.

Limitations and Conclusion

Our findings demonstrate the value of qualitative exploration of cross-professional interactions between nurses and law enforcement officers in the hospital, particularly in understanding the meaning-making and interpretations ascribed to interactions. The study was limited, however, in that complete demographics were not provided by participants, and not all participants identified themselves as male or female. There were also no male-identified nurse participants, who may have very different experiences of law enforcement interactions.

It is hoped that this study will help clinicians to gain added perspective on the ways that power operates in these settings, and that this knowledge will not only inform but will give rise to tactics for delivering the best care despite the overwhelming constraints on clinicians' freedom to act in these biopolitical spaces. In exploring how nurses and law enforcement officers think about and describe their experiences, nurses and hospital systems may develop deeper understanding and appreciation of barriers to care for incarcerated patients, and of the challenging experiences nurses face in caring for these patients. The nurses' expressed feelings of intimidation, stress, and impaired self-efficacy in this dynamic underscore the need for institutional support and prioritization of caring practices, and identification of the ways in which carceral practices impair care, as well as nurses' safety. Additional research is needed in the

specific ways this struggle for power between institutions and their political actors impair caring practices, as well as on the emotional and psychological sequalae of these interactions.

Chapter 4

“We’re Not Caring Angels”: Gender Influences at the Collision of Caring and Carceral Institutions

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Statement of Significance:

What is known, or assumed to be true, about this topic: We know that population of incarcerated people in this country is significant, and the aging population requires increasing amounts of medical care. Caring for persons in custody is a required duty for many nurses. While there is a small amount of literature on dynamics between nurses and law enforcement in the custodial setting, there is a paucity of literature on the topic of nurse and law enforcement interaction in the hospital setting.

What this article adds: This article adds a qualitative exploration of how nurses and law enforcement officers think about and describe their experiences. With this new information, nurses and hospital systems may develop deeper understanding and appreciation of barriers to care for incarcerated patients, and of the challenging experiences nurses face in caring for these patients.

“We’re Not Caring Angels”:
Gender Influences in the Intersection of Caring and Carceral Institutions

Abstract

Objective: To give voice to the lived experiences of nurses and law enforcement officers who interact with one another in an acute hospital setting, while gaining understanding of individual perspectives and unique experiences, as well as how they interpret these experiences.

Methods: This qualitative study used interpretative phenomenological analysis (IPA) to strive to meet the study objectives.

Results: There is a paucity of literature on the topic of nurse and law enforcement interaction in the hospital setting. Overwhelmingly, participants described a contentious dynamic between nurses and law enforcement officers in the hospital, wrought with argument, stress, and a feeling of coming from “different worlds”. The influence of gender was apparent to the female-identified participants, and gender constructs and therefore gender role conflict were critical points of contention.

Conclusion: In exploring how nurses and law enforcement officers think about and describe their experiences, nurses and hospital systems may develop deeper understanding and appreciation of barriers to care for incarcerated patients, and of the challenging experiences nurses face in caring for these patients. The nurses’ expressed feelings of intimidation, stress, and impaired self-efficacy in this dynamic underscore the need for institutional support and prioritization of caring practices, and identification of the ways in which carceral practices impair care, as well as nurses’ safety.

Introduction

Caring for people accused and convicted of crimes is a required duty for many nurses working in acute care settings. Patients in custody increasingly receive medical care in hospital settings; accounting for about 20 percent of prison healthcare spending (J. Travis, Western, & Redburn, 2014). For registered nurses engaged in the provision of this care, strict adherence to professional ethics and expectations of usual care may be challenged by the presence of, or interaction with, correctional officers. Research conducted in correctional settings has shown that the tensions between custody and nursing care have a decisively deleterious effect on nursing practice (D. Holmes & Federman, 2003), Law enforcement is tasked to keep the patient under strict surveillance, and logics of control and punishment can interfere with nursing practice and impede delivery of care by restricting, altering or co-opting nurse-patient relationships. Where institutions of custody and care collide, nurses may be forced to choose between complying with law enforcement's demands or practicing nursing according to recognized standards of ethical care.

This paper presents results from a qualitative study designed to give voice to the lived experiences of nurses and law enforcement officers who interact with one another in an acute hospital setting, while gaining understanding of individual perspectives and unique experiences, as well as how they interpret these experiences. The paper focuses on an important aspect of this as reported by participants: the ways in which gender and power dynamics influence caring practices in nursing, and the ways in which they fueled conflict between the two groups.

Background

It is critical to examine power dynamics as operationalized through gender and gender roles in relational exchanges between actors of the caring and carceral professions, particularly

when these roles collide. These professions are nearly monopolized by male-identified (law enforcement) and female-identified (nursing) individuals, and feminist theory offers an appropriate to analyze relationships between nurses and law enforcement officers in a hospital setting. This study was conducted in San Diego County, California, where approximately 85% of gender-identified registered nurses are female (Rappley, 2015) and approximately 84% of gender identified law enforcement officers are male (SDPD, 2019).

The concepts of men/women and of masculine/feminine are often presented as archetypal and oppositional forces. Feminist theory-based research seeks understanding of the related gender inequities by examining social roles, expectations, and experiences. These are often identified through experiences of discrimination, objectification, oppression, stereotyping, or patriarchal behavior (Zalk & Gordon-Kelter, 2019). Application of such theory can thus illuminate the ways in which assumptions about gender identity and thereby expected behaviors may create disempowering relationships, particularly for women. In her work on gender and power in organizations, Nicolson asserts: “Gender relations are the site for power struggles and power-based conflicts in work organizations… power remains firmly in the hands of men, although not without resistance from other men and women” (Nicolson, 2015, p. 25). This may be particularly true where professions largely populated by a single gender come into conflict. Disempowerment of the female-identified may particularly manifest when relationships or interactions are imposed—in this case, necessitated in the performance of one’s job—and women do not have the option to avoid this dynamic (Cifor, 2017).

Further, in this study is a specific element of feminist theory seems especially relevant: that of performed gender role conflict. Gender role conflict occurs when proscribed rigid, sexist, or limiting gender roles result in restriction, devaluation, or violation of a particular group, and

has been amply demonstrated to produce impaired self-esteem, anxiety, and depression (Beaglaoich, 2014). Typically, women are ascribed nurturing characteristics: prioritizing the welfare of others; being helpful, kind, and caring; peacekeeping. In contrast, men are socially ascribed agentic characteristics, and are allowed and encouraged to be assertive, powerful, controlling, dominant, and forceful (Eagly A.H., 2001). Where circumstances cause these roles to disintegrate—for example, where a female-identified nurse is charged with the care of a particular patient, thereby giving the nurse control of the care situation—retribution, or aggressive efforts to re-establish the usual social order can result.

This is unfortunately common not only in the conflict of nurses with law enforcement, but within the entire profession of nursing. Burton (2020) asserts that in fact the enforcement of hegemonic femininity throughout nursing results in an oppression that demands and enforces performative gender behaviors, even unto extremes. This means that nurses can be doubly disempowered when dealing with law enforcement: first by the nature of their status *as* nurses, and secondly by assertions that law enforcement must maintain complete control of incarcerated patients and by extension their care.

Methodology

Qualitative research is particularly well-suited to answer research questions aligned with nursing's iterative, contextual, and hermeneutical nature, and allows for exploration of complexities inherent to the experiences of caring for patients in complex settings. This study used interpretative phenomenological analysis (IPA) as the primary approach to understanding the lived experiences of interactions between nurses and law enforcement officials and elicit participant interpretations of their experiences. The research design was selected based upon the nature of the research problem, the researcher's personal experiences, existing literature on this

and related phenomena, and the expected study audience (Lincoln & Lynham, 2011). IPA in particular was well suited to answer the research question because of its reliance on purposive sampling, of which the power and logic "lie in selecting information-rich cases for in-depth study. Information-rich cases are those in which one can learn a great deal about issues of central importance to the purpose of the inquiry. Using information-rich cases yields insights and in-depth understanding" (Patton, 2015, pp. 264-265).

Setting and Recruitment

The study was carried out San Diego County, California and was determined to be exempt from human subjects research oversight by the University of California Irvine Institutional Review Board. Recruitment was carried out via advertisement on social media and with flyers in hospital and law enforcement departments. Registered nurses responded very quickly to the social media posts however law enforcement officers were more often directly referred by other law enforcement participants. Interested participants contacted the principal investigator (PI), study information was reviewed, and if the participant consented, an interview date and time scheduled.

Information on the study purpose, description, research design, and timeline provided to all participants prior to scheduling the interview. Potential and enrolled participants were also encouraged to share the study information with colleagues. Semi-structured interviews were recorded, transcribed, and analyzed by the PI with input from the co-investigators. All study participants received $50 at the conclusion of the interview, which lasted approximately one hour.

Sample

Participants were English speaking nurses and law enforcement officers who identified as having interactions the other profession in a hospital setting due to a person in custody needing medical care. The participants had to both remember the experience and be willing to share their thoughts, feelings, and reflections on the interaction. In total, nine law enforcement officers and ten registered nurses participated. Due to the perceived sensitive nature of the interviews, not all participants were willing to provide complete information on gender, age, years of experience, or specifics related to their employment. The proffered participant demographic information can be found in Table 1.

Notably, a tenth law enforcement officer was scheduled for interview but ultimately eschewed participation, citing the Derrick Chauvin's trial as a reason to not participate. An additional four law enforcement officers signed up to participate but did not log on for their interviews.

Methods

Each participant was invited to complete a semi-structured interview via Zoom. Participants were provided study information via email to review in advance. Prior to beginning the interview, the study information was reviewed, and participants given the opportunity to ask any questions. Participants were given permission to have video on or off during the interview, and the PI asked permission prior to beginning recording.

During the interview, participants were asked to share their experiences working with nurses or law enforcement officers in a hospital setting, and to describe the types of challenges encountered in their interactions. Each interview lasted approximately one hour. Interviews were audio-recorded, and if the participant chose to have their camera on for the interview, the PI kept field notes on facial expressions or behaviors. The interviews were then transcribed for analysis.

Three nurse participants also sent follow up emails with additional thoughts and reflections in written form following the interview, which was included in the analysis.

Analysis

Data were analyzed following IPA methodology. Analysis of qualitative data moves from the particular to the shared, and from the descriptive to the interpretive (Smith et al., 2009, p. 79). This research design is grounded in a postmodernist approach, which asserts both the heterogeneity and contextuality of knowledge (Kvale, 1994). While it is obvious that statistical generalizability is not relevant for a qualitative study, analytical generalizability was sought. Analytical generalization "involves a reasoned judgement about the extent to which the findings from one study can be used as a guide to what might occur in another situation" (Kvale, 1994, p. 233). Analysis followed a cycle of both iterative and inductive coding. Emotion coding was especially appropriate in that this study sought to explore interpersonal and intrapersonal experiences and actions and provided insights into participants' worldviews and perspectives (Miles, 2014). The IPA analytical steps as delineated by Smith et al. include: (1) "immersing oneself in the original data" by listening intently to the audio recording and reading and re-reading each transcript (p. 82); (2) "examining semantic content and language" of the data to identify and note content of interest (p. 83) (3) "analyzing exploratory comments" from the first analysis to identify and develop emergent themes within the data (p. 91), (4) discover connections across emergent themes by utilizing abstraction, polarization, contextualization, numeration, and function (pp. 96-98); (5) moving to the next case to repeat the process; and finally (6) looking for patterns across cases.

Results

The empirical data were rich in both explicit depictions of experiences, and in the depth of reflection and meaning making. Overwhelmingly, participants described a contentious dynamic between nurses and law enforcement officers in the hospital, wrought with argument, stress, and a feeling of coming from "different worlds". The dynamics of power and control, both physical and relational, were frequently cited and are further explored elsewhere. Critical to IPA is the participant's description of meaning-making, and the influence of gender was apparent to the female-identified participants, and gender constructs and therefore gender role conflict were critical points of contention. This paper therefore focuses on the theme of Gender Dynamics in interactions between nurses and law enforcement officers in the hospital setting.

We're Not Caring Angels

The participants shared their view that nurses are expected to behave in a compliant and docile fashion, and that this expectation is born of a socially constructed image of nurses as caring angels and hand-holding maidens. They also asserted that men, particularly in law enforcement, are seen as protectors, and expected to have total control of the situation. Several officers viewed themselves as critical to safety and protection and commented that because nurses are female, officers "definitely do not want them to get hurt". When nurses set firm boundaries or otherwise asserted their own power and control, a negative response from law enforcement further fueled conflict. Nurses' behavior in such cases conflicted with that generally expected from a woman in a caring profession, and law enforcement officers reacted with attempts to reassert their authority:

> "It was kind of a male arrogant, it was like an arrogance with him… It was a gut feeling, like, you know when somebody… sees you as somebody they don't have to take as

> seriously because you're a female… It was just an arrogance and like a dismissive attitude that wasn't just related to our jobs. You know, he got irritated that I had the audacity to question him and I can tell…I don't know him, but, there was like a machismo element going on there."

Interestingly, a female law enforcement officer described the dynamic similarly:

> "From the law enforcement perspective, and this is not saying all male officers, but a lot of men, officers, it's that power thing that macho things or to speak that I'm the police and we rule we law and order, that kind of thing. I guess what you've seen back in the day, when nurses are the motherly type, the womanly type, the caring concern, not the meek and mellow, but somewhat along those lines. And I think that's why sometimes you have that butting of the heads…and sometimes the way the nurses behave it could be totally opposite. But because of the history of what nurses look like, and the history of what law enforcers look like, then that's kind of embedded in us and it carries over."

The nurses in particular identified their roles as being shaped in a "sexist patriarchal society," sharing the sentiment with eyerolls and exasperated tones. They voiced how the actual lived obligations of a nurse were disruptive to this hegemony. Though the nurses acknowledged and recognized this dynamic throughout the course of their interactions, several also stated that nurses actively resist this stereotyping. The nurses felt they were often not "heard" or "taken seriously" because they are women. Law enforcement officers, however, reported that many become upset by nurses' assertions of authority, and do not care to listen to what they have to say because it is "coming out of the mouth of a woman":

> "We have a hard a time listening, and that's probably where the problem comes in with the nurses and the male officers competing because they don't listen to what that nurse is

trying to tell you of what's going on and what's happening…Probably too, like they don't have to listen to what a female is saying to them, so they just feel like they're always the dominant, where they're not, So, they just don't wanna listen or agree to anything just because it's coming out of the mouth of a woman."

They Deserve it Because They Weren't Very Friendly

Several law enforcement officers further described the type of behavior they expected and approved of from nurses. These officers commended the nurses for their caring practices, but also commented on the challenges those practices cause, asserting that "loving conversations" were not appropriate with incarcerated patients. When sharing about favorable interactions with nurses, most officers described instances in which nurses provided care to the officers themselves. When the PI attempted refocusing the conversation on interactions in the hospital around a person in custody, the law officers continued to provide examples of when the nurses were perceived as friendly, accommodating, welcoming, and prioritized the officer's needs and wants. Many equated nurses' professionalism with what they perceived as niceness. Of note, some of the officers explained that the perceived "friendliness" of nurses toward law enforcement influenced where they would take a patient, even if it meant driving further away:

> "Okay, well, for me, the (redacted) Hospital is the best one to get it assigned because all the staff is friendly… all the nursing staff talks to us, acknowledges us, ask us if we have breakfast, lunch and dinner for your sign in the evening shift, they bring us food."

Law enforcement's perceptions of unfavorable behavior from nurses were most often described as disrespectful or being unfriendly. Many officers felt ignored and dissatisfied if a nurse spoke to the patient first or asked the patient questions about their condition—instead of asking the officer. Several felt that the officer should be asked all questions and indicated that speaking to

the patient before speaking to the officer was disrespectful and negatively affected the relationship between nurse and officer. Perception of the nurse as respectful, professional, nice, and welcoming was clearly imperative to not escalating conflict. The officers provided examples in which perceived disrespect from nurses was grounds for retaliatory behavior and making the nurse's job more difficult. As one officer said, "If they give us bad looks or don't acknowledge us, it's gonna, our interaction is not gonna be a great one." Another remarked, "I've heard horror stories where they make some nurses cry (laughs), uh, but, you know, most of those stories, I hear the background behind it, and they deserve it because they weren't very friendly with us." When asked why law enforcement might feel nurses were often rude or disrespectful, one nurse suggested that:

> "Nurses aren't fitting the gender role that's expected of them. I think it impacts (law enforcement's) perceptions of, they feel like we are disrespectful and rude, right? Because we're supposed to be these docile angels that just flutter in and provide care, we hold people's hands, we bring what is needed to those who need it, and that's not who we are, we're not... Handmaidens, but that's very much how we're portrayed and movies and media."

Another nurse noted that in addition, the nurses are often "calling them (officers) out" for doing something wrong: "I think that when they're (law enforcement) doing something that they're not supposed to be. I think that most people perceive disrespect and rudeness when individuals call them out when they're doing something wrong, and so I think that law enforcement probably feels that because often they're doing something wrong...." forcing the nurse to object.

Discussion

Gender clearly affects power relations, which “symbolically reproduce the allocation and hierarchization of roles between men and women” (Galbany-Estragués & Comas-d’Argemir, 2017, p. 361). Existing literature asserts that the dominant socially constructed image of a nurse is one of a woman who is especially kind, caregiving, virtuous, and a healer (Burton, 2020) Nurses are often presented as the “hand holder and less skilled” provider (Price & Hall, 2013, p. 1506). The pure, virtuous, maternal, handmaiden imagery is both historical and pervasive (Price & Hall, 2013), and several nurses commented on the fallacy of this imagery and its contribution to conflict with officers. As noted by one of the nurses in our study, this imagery is not of benefit to the profession, as it necessarily disempowers the nurse and places them in a subordinated, helpmeet position rather than one of autonomy and/or strength. Gender thus exerts a direct influence on the association of nursing care with women and intensifies the difficulty that nurses face in receiving social recognition for power or authority in their profession (Galbany-Estragués & Comas-d’Argemir, 2017).

Further, characterizing nurses as angels is a common trope, implying that the nurse in fact a religious servant.(Price, McGillis, Angus, & Peter, 2013) The angelic image of nurses can be conceptualized as creating for nurses the experience of “an oppressed group. The dominance of the oppressor… marginalizes the oppressed group and may lead to the development of low self-concept which can in turn lead to negative self-presentation” (ten Hoeve, Jansen, & Roodbol, 2013, p. 27). This was reflected in our findings that law enforcement expected a certain standard of behavior, often interchanging professionalism with kindness, and that privileged their treatment over the patient’s. Several officers expressed shock, confusion, and a deep sense of disrespect due to the perception that nurses often took the “side” of the incarcerated person as

opposed to the officer. For the nurses, however, the first duty is to the patient, and this clearly confounded many of the officers. Several examples were provided in which the nurse prioritizing the patient over the officer was seen as disrespectful, and in some cases even ridiculous and grounds for retaliation from officers.

Both nurses and law enforcement officers provided examples and interpretation of how male law enforcement officers exhibited increasingly forceful behaviors when nurses exerted power, both with their bodies and through behavioral intimidation tactics. Nurses frequently described aggressive posturing, and several used the terms *machismo* and *ego*. Law enforcement also voiced the expectation that the nurses should behave in a caring and angelic way, some of them even extending the expectation of caring subservience to themselves. Some officers stated they were more likely to bring patients to hospitals in which nurses were perceived as overtly courteous and welcoming to law enforcement, putting them at the front of the line, and even serving them coffee and food.

This is congruent with Nicolson's (2015) assertion of gender relations as a site for power struggles in which women resist a male grasp on power and authority, further articulated by many of the nurses. Feminist theory scholarship also suggests that these behaviors may be an exhibition of fear and anxiety secondary to a woman's exertion of power (Nicolson, 2015; Usher, 1991). In attempts to overcome the constraints of custodial boundaries, the nurses provided examples of the ways in which they confronted male-enforced authority by asserting and advocating for the care they needed to provide for the patient. Law enforcement officers, however, asserted that this was a disrespectful undermining of authority, and a dangerous attempt to shift the power of decision making away from custodial authorities.

In describing archetypal expectations of male and female behaviors, particularly in the "protecting" and "caring" professions, physicist and feminist scholar Evelyn Fox Kellar described ways in which gender identify formation can amplify development of autonomy and dominance. For Kellar, young males may develop gender identity in opposition to what is defined and experienced as feminine. This invokes an internal anxiety about self-defined gender identity, and is supported by the wider cultural anxiety that encourages and enables posturing of masculine dominance behaviors because perceptions of safety and security come from successful domination (Kellar, 2003). In our study, some nurses spoke negatively of their colleagues who seemed to side with officers on the basis that the patient was deemed a criminal. This reflects traditional delineation of "offenders" and "warrior defenders of safety" as contrasting archetypes (Jackson et al., 2013), and reaffirms control as a nexus of masculinity. In interactions between (largely female-identified) nurses and (largely male-identified) law enforcement, this compounds conflicts between the opposing archetypes of men/women and masculine/feminine roles. Interestingly, in member checking during our analysis, two law enforcement participants denied that gender dynamics played any role in nurse and law enforcement officer interactions.

Limitations and Conclusion

Our findings demonstrate the value of qualitative exploration of cross-professional interactions between nurses and law enforcement officers in the hospital, particularly in understanding the meaning-making and interpretations ascribed to contentious interactions. The study was limited, however, in that complete demographics were not provided by participants, and not all participants identified themselves as male or female. There were also no male-identified nurse participants, and such nurses could have very different experiences of law enforcement interactions.

In exploring how nurses and law enforcement officers think about and describe their experiences, nurses and hospital systems may develop deeper understanding and appreciation of barriers to care for incarcerated patients, and of the challenging experiences nurses face in caring for these patients. The nurses' expressed feelings of intimidation, stress, and impaired self-efficacy in this dynamic underscore the need for institutional support and prioritization of caring practices, and identification of the ways in which carceral practices impair care, as well as nurses' safety. Additional research is needed in the specific ways that gender dynamics impair caring practices, as well as on the emotional and psychological sequalae of these interactions.

Chapter 5:

Synthesis and Conclusions

There are few nursing- oriented publications on the intersection of nursing and carceral practices. Existing publications are focused almost entirely within the carceral setting, and none of those studies analyze the dynamics within an acute care environment. The purpose of this qualitative study was to give voice to the lived experiences of nurses and law enforcement officers who interact in the hospital setting, gain understanding of their individual perspectives and unique experiences, and discover how they interpret these experiences. The aim of the study was to understand the lived experience of nurses and law enforcement officers; particularly perceptions of role and responsibilities, experiences with self-efficacy and moral injury, perceptions of power, and ways in which standards of care are affected in this dynamic. The study, thus far, has resulted in three papers.

Understanding the origins of this dynamic prompted exploration of hospitals as total institutions. As Goffman wrote in *Asylums,* the participants made visible the ways in which they were reduced, or reduced others to the roles ascribed to them as political actors which existed to serve the institution; a kind, subservient nurse, a powerful and strong officer in uniform, and a voiceless patient/offender. Because Goffman did not identify modern acute care hospitals at total institutions, effort was devoted to justifying how hospitals operationalize totalizing practices, particularly through mortification of self and a formally administered way of life. Both the carceral and the caring domains operate within highly bureaucratic, monitored, and panoptic environments with stringent chains of command. Goffman's Total Institution (1968) thus was ultimately a powerful tool for framing the power dynamic in this study. Study participants frequently discussed feeling that they come from two worlds, with unique sets of power

structures and rules that are forcibly adhered to upon crossing the threshold. The participants also provided many examples of dehumanizing practices that they themselves were subjected to, and the ways in which they dehumanized others.

The findings of this study are also uniquely situated in a supposed "caring" environment, and reflect the thoughts, feelings, reactions, and meaning making of nurses and law enforcement officers. Feminist theory was critical to developing understanding of the meaning-making of the participants in this context, as they voiced repeatedly and consistently their reflections on the ways in which both gender and gender roles heavily influenced the power exchanges and authority. All described interactions with one another in varying degrees of contentiousness, asserting the importance of considering the ramifications to all of the political players involved, including the patient. Participant descriptions illustrated the ways in which this is operationalized.

Synthesis

> And perhaps our life is still governed by a certain number of oppositions that remain inviolable, that our institutions and practices have not dared to break down. These are oppositions that we regard as simple givens: for example, between private space and public space, between family space and social space, between cultural space and useful space, between the space of leisure and that of work. All these are still nurtured by the hidden presence of the sacred (Foucault & Miskowiec, 1986, p. 23).

Overarchingly, the study results made visible the challenges and resulting conflict at the convergence of political actors from these carceral and caring institutions. Foucault's work on biopolitics, and in particular his work on the clinic and the medical gaze (1973), asserts that the body and place as they are positioned and function in an institution is of great significance, and

this work helps to situate the hospital as a critical point in the intersection of two forces of institutional power. Nurses are deeply aware of power relations within the hospital (Holmes, Murray, & Knack, 2012), and Foucault and Goffman provided substantial contribution to the understanding of power relations and the ways that nurses work within a multifaceted administrative state apparatus (Hacking, 2004). Amplifying the perception of the hospitals as total institutions and the assertion of power, the concept of *territory* was an important reflection from nurses and law enforcement. There was a pervasive assertion that inside the hospital's walls was the nurses' "territory" or "house", and with that territory came an expected adoption of the rules and power structures within the walls. It was unclear to most participants where, how, or even if law enforcement fit within the power structures of the hospital, but overwhelmingly nurses voiced that law enforcement's presence was generally of little benefit, and that they more often than not took up physical space in a way that was seen as obstructive to the nurse's comings and goings. A foundational definition of territory comes from Max Weber (Weber, 1968):

> The state possesses an administrative and legal order subject to change by legislation, to which the organized activities of the administrative staff, which are also controlled by regulations, are oriented. This system of order claims binding authority, not only over the members of the state, the citizens, most of whom have obtained membership by birth, but also to a very large extent over all action taking place in the area of its jurisdiction. It is thus a compulsory organization with a territorial basis. Furthermore, today, the use of force is regarded as legitimate only so far as it is either permitted by the state or prescribed by it ... The claim of the modern state to monopolize the use of force is as

essential to it as its character of compulsory jurisdiction and of continuous operation (p. 56)

This definition aligns with the expressions of the nurses in particular, in which *my territory* or *my house* implies sharply defined boundaries in which power can be exercised, and the permissible use of force, by whom, and when, is to be dictated by those with ownership within the territorial bounds.

A critical finding was that the nurses do in fact perceive that officer presence, and their perceived enforcement of power, deforms nursing care, and the ramifications and detriment to the patient are dependent upon a nurses' willingness or ability to resist. Many of the nurses reported witnessing a particular event, such as police-initiated violence against their patient, that changed their interactions, perceptions, and attitudes against law enforcement going forward. Though these experiences were lesser than the usual mundane and seemingly inconsequential interactions and minor frustrations, they enveloped the nurses' perceptions of law enforcement in a negative light, wrought with suspicion and mistrust. Subsequently, law enforcement officers cited this generalized ascription of "bad guy" as a burden they bear painfully. Nurses also consistently reported unfavorable feelings secondary to interacting with law enforcement, including impaired self-efficacy in their job duties, feelings of anxiety, anger, and moral distress. Reported consequences to patients ranged from privacy violations to human rights violations and even death.

The study findings further illuminate the ways in which nurses and patients alike are actors in the biopolitical power structures and spaces of healthcare and the social nursing process. Agamben's biopolitical theories of *zoe* and *bios* were brought to life through nurses' descriptions of their fear of losing their own political agency should they not comply with law

enforcement. Another important component to the nurses' perceived ability to maintain equitable standards of care was knowledgeable and supportive leadership that "had their back". Even without the influences of criminalization and detention subjected by law enforcement, the biopolitical sphere of the hospital already places patients in the zoe-bios antimony. The nurse participants described the ways in which biopower is operationalized; although nurses enact the social nursing process wearing socially constructed identities marked by compassion and caring as badges of honor, the act of nursing itself was influenced and changed in this biopolitical space takes place in a biopolitical space (Chinn & Wheeler, 1985). To function daily, nurses themselves must operate in these biopolitical spaces and maintain their own bios by absorbing and adhering to the norms of the political positions of those around, superior, and inferior to them (Georges, 2014). This was amplified with the presence of law enforcement and the corresponding fear of coming under carceral control themselves. Though patients suffered from nurses adhering to the carceral power's demands through alterations of deformations of caring practices, the nurses described the ways in which they, and their peers worked to maintain their own political agency through preservation of social norms and aversion to disrupting the status quo (Thorne, 2014). Even while espousing the importance of compassion and caring, a mission to relieve suffering, it became clear the ways in which nurses nonetheless participate in the upholding of the very structure that causes harm. This cogent revelation in the data brings us to "…question the illusion of nursing as we currently define it (as caring, as ethical, as the most trusted) while pairing it with the more nuanced realities of nursing as commodity, as extractive apparatus, as governmentality, and as complicit in white supremacist patriarchy" (Dillard-Wright, Walsh, & Brown, 2020, p. 134).

Recommendations for Further Study

The absence of the voice of the patient in this study, who arguably bears the brunt of the consequences of this dynamic, is profound. Though many of the nurses identified the voice-lessness of their patient and positioned themselves to speak on their behalf, the reality is many of these patients do have a voice of their own, if and when they are allowed to speak and be heard. Future study of the lived experiences of the person detained is essential in order to fully grasp the extent of the detriment and implications resultant of this struggle for power.

The results and synthesis of this study align with Georges' (2013) theory that biopower and suffering are inextricably linked to the presence or absence of compassion in the context of nursing practice. Nursing theory has just begun to reap the benefits of epistemic diversity and a growing appreciation for the sociopolitical situating of nursing practice. Because of this burgeoning adjustment in epistemic lens, the Emancipatory Theory of Compassion (ETC) has been built upon the philosophical underpinnings of Foucault, Agamben, and critical feminist paradigms (Georges, 2008). Foundationally, the ETC is built on the bedrock of the Foucauldian tenet that biopower is the ultimate locus of power (Foucault, 1975). It is hoped that dissemination and further study of this phenomenon will in some small way draw back the curtain on what Georges describes as the *unspeakable*; the fact that erasure of personhood and suffering are accepted social processes, even in nursing (Georges, 2014). Left unaddressed, the *unspeakable* has immense power and potential to cultivate inequitable power relations resulting in violence so significant, that to render compassionate care is impossible. Georges' (2013) summation on the matter is poignant: "In sum. It has the power do destroy nursing" (p. 7).

The implications of these findings and opportunities for further study are immense, both for the nursing profession and the patients in their care. The results of this study provide

alarming examples of deformed caring practices and assert the necessity for continued unearthing and discussion of how nurses can, and should, navigate law enforcement interaction. As voiced by the study participants, leadership and organizational support is critical, and we must not wait until catastrophic events occur before institutions recognize and address this ethico-legal challenge that both nurses and officers face. While many of the nurses spoke about the struggle and necessity of the small moments of resistance, it was made clear by the participants that the "argument" is rarely solved by one officer and one nurse; in fact, they are fighting the battles of their institutions, operationalizing totalizing practices in a zone of indistinction (Agamben, 1995). In this zone we see a re-emergence of new sovereignty with questionable and variable levels of accountability, ambiguous and arbitrary rules written in real time, and unilateral decisions made regarding the life and death of a shackled, silenced body in the bed.

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Appendix A

Registered Nurse Demographic Information.

Participant Number	Nursing Environment	Years of Experience	Identified Gender
RN 1	Trauma Intensive Care	8	Female
RN 2	Trauma Progressive Care	7	Female
RN 3	Trauma	9	Female
RN 4	Surgical	7	Female
RN 5	Medical Intensive Care Unit	10	Female
RN 6	Burn	27	Female
RN 7	Trauma	16	Not identified
RN 8	Emergency	2	Female
RN 9	Cardiovascular Intensive Care	18	Female
RN 10	Not identified	4	Not identified

Law Enforcement Demographic Information

Participant Number	LE Environment	Years of Experience	Identified Gender
LE 1	Border Patrol	11	Male
LE 2	Border Patrol/ City Police	10	Male
LE 3	Sheriff's Department	17	Not identified
LE 4	Probation Officer	6	Male
LE 5	City Police Department	5	Male
LE 6	City Police Department	6	Female
LE 7	City Police Department	19	Female
LE 8	Federal Law Enforcement (undefined)	16	Female

Appendix B

Coding Table.

Code Label	Code Cluster	Code Family
Shackle	Shackles and Restraints	Physical Control
Chain		
Cuff		
Forensic Restraint		
Handcuff		
Beat up	Assault	
Shot		
Pepper Spray		
Suffocate		
Territory	Physical Space	
Getting in the way		
Our house		
Their house		
In these walls		
our world		
different places		
choose the hospital		
Two way street	Reciprocal relationship	Relational Control
don't help us we won't help them		
scratch my back I'll scratch yours		
have our back		
Information	Witholding information	
A right to privacy		
Witholding information		
Being nosy		
Gathering information		
None of their business		
Disclosing information		
Interfering with investigation		
These are my expectations	Setting boundaries	
No. That's inappropriate.		
This is non-negotiable		
Its about setting firm boundaries		
Putting our foot down		
Overstepping boundaries		
Our house our rules		
Take it up the chain	Pulling Rank	
Speak to the supervisor		
I'm in charge		

I'm a Corporal		
I'm a Federal agent		
Getting the charge nurse		
Obstructing my job	Interfering	
Hindrance		
Disruptive		
Interrupting		
Interfering with care		
Make it difficult for them		
Rush the nurses		
They yell	Unprofessional Behavior	
Intimidation tactics		
Threatening		
Disrespect		
Pushy		
Unkind and rude		
Harassment and bullying		
Badgered and Belittled		
Rolling eyes		
Bad attitude and bad looks		
Pulled from one world to another	Different Worlds	Meaning Making
Come from different worlds		
Where does one world end and another start		
We come from totally different places		
We push and push and broke the wall		
We are antithesis		
Majority men, majority women	Gender dynamic	
All of the negative experiences are with men		
They're men, its intimidating		
I'm a female and they are bigger		
We live in a sexist society		
Men are protectors		
Force responds to force, men are forceful		
Machismo		
Nurses aren't supposed to say no		
Males want to be dominant		
They don't have to listen to a female		

Women are a little inferior		
For officers it’s a macho thing, a power thing		
caring angel		
meek and mellow		
They're biased	Bias, Media, and Politics	
Take down their bias		
High emotion politically and with last summer		
The bias comes from the media		
They're more focused on the media		
The Derek Chauvin trial		
Their political beliefs		
Protesting left and right		
Black Lives Matter		
The Obama administration		
Its where we are politically		
liberal nurses		
frowned upon because of political system		
George Floyd and Breonna Taylor and all that		
Stressful	Emotional response	emotional response/implications
its frustrating		
concerning		
it really bothers me		
it feels really slimy		
it feels wrong		
I was angry, I was sad		
An uncomfortable situation		
very emotional		
feeling out of my role		
I was bawling my eyes out		
I feel out of my role		
I feel so much pressure, anxiety, and fear		
It is disheartening		
It just breaks your heart		
I feel numb		
I'm doing a disservice	Implications	
Destroys the trust		

I can't do my job
Not able to provide the same care
There are retention implications
The bad guy goes free
Skin breakdown
The patient suffers
Violates their privacy
The patient is harmed
There are complications
It increases mortality
A disservice to my patient
It drives people away
It puts the patient, nurse, and organization at risk

Tug of war	Describe the dynamic

Power strugge
Tense
Its gotten bad, very bad
Disrespectful
Stressful
Challenged and overwhelming
There's so much tension
It feels really slimy
I've never felt glad they are there
Animosity
The relationship is strained
A struggle
A butting of heads
Not cooperative
We keep pushing and pushing
We are always at odds.

Appendix C

Participant Characteristics

RN 1

RN 1 described being led to nursing after being in a career that did not provide intrinsic fulfillment. Specifically, she felt nursing would bring her more than just monetary gain and would be an opportunity to give back. She felt that she was a naturally caring and giving person, and she saw a lot of needs unaddressed in the community. She also experienced a close family member with cancer, and saw many unaddressed needs in her care, and realized that she is a good advocate. She described that she interacts with law enforcement in the hospital at least weekly, and there are some periods in which she has daily interactions. Her most frequent interactions are with city police, Border Patrol, ICE, and the Sheriff's Department.

RN 2

RN 2 shared that she became a nurse because of a love for taking care of people and advocating for vulnerable populations, particularly the elderly. She described that she stays in nursing because she has seen that it is not only patients that need someone to advocate for them, but nurses as well. She described that especially in trauma, she constantly must advocate for resources for both the patients and the nurses. She stated her interactions with law enforcement are daily, and that she most frequently interacts with border patrol, and officers with federal and state prisoners, as well as city police.

RN 3

RN 3 described becoming a nurse because of her experiences when her grandmother was ill, in which there was much she did not understand regarding the care and her grandmother's disease progression. She felt she would be good at helping people understand what was

happening when they are ill, and that being a nurturing “people person” would make her a good nurse. She states that some days she wonders why she is still a nurse, but she mostly stays because she loves her role in making sure everyone has the best possible outcome. She described that she recently left hospital nursing, in part due to the stress of frequent law enforcement interactions, which were at least monthly.

RN 4

RN 4 described becoming a nurse because she perceived herself as a strong advocate. She described the frequency of her interactions with law enforcement as “too often”, which she equated to about weekly. She shared she interacts with “every type” of law enforcement there is.

RN 5

RN 5 described becoming a nurse because of a family member she looked up to whom she felt shared similar empathetic character traits. She stated that she has wanted to be a nurse for as long as she could remember. She stated she is often unsure why she is still a nurse, but stated that she feels like she can act as a voice, or a liaison for people, especially in the ICU. She stated she interacts with law enforcement approximately monthly, and most often with border patrol and ICE.

RN 6

RN 6 describe becoming a nurse because it was an opportunity to move out of her house. She wanted to travel, and nursing was an opportunity to go to a different country. She described that she liked taking care of people. She described that interacting with law enforcement “comes in waves”, and that she interacts with them at least monthly, and sometimes law enforcement lines the whole hospital hallway.

RN 7

RN 6 stated she became a nurse because of the science behind the practice, and the ability to provide care at the same time. She stated that she stays in the profession because there is always something to learn, and she feel honorable and proud of the outcomes she produces along with her organization. She stated she interacts with law enforcement almost every day that she works, and even if she is not personally interacting with them they are "always there".

RN 8

RN 7 became a nurse because they had family in emergency medical response, and perceived themselves to be a person more empathetic than most. They described liking the ability to help someone when they are at their weakest, and that nursing is a calling. RN 7 described interacting with a variety of law enforcement at least several times a month.

RN 9

RN 9 described becoming a nurse because she was deeply influenced by a nurse who cared for a relative. She described staying in the nursing profession because she loves the challenge of high acuity patients and taking care of people. She chose nursing over medicine because she did not feel they spend as much time with the patients. She stated she interacts with law enforcement approximately once every one to two weeks.

RN 10

RN 10 described always wanting to do nursing. A close family friend was an LVN, and felt like they liked helping people, so nursing would be a good fit. RN 10 stated they interact with law enforcement in the hospital at least weekly.

LE 1

LE 1 described holding a bachelor's degree in psychology. He was an aspiring social worker but was unable to complete the degree. LE 1 shared he joined border patrol for economic reasons. LE 1 shared he interacts with nurses in the hospital approximately once a week, which he signs up for as overtime shifts.

LE 2

LE 2 described joining border patrol to help stop the flow of drugs entering the country after a family member became addicted to drugs. He described it was an opportunity to be part of the solution. LE 2 shared he left border patrol to join the police department in part because the police are held in higher regard than border patrol. He stated that staying in the profession is hard because he feels they are often abused, but that they do still get support from the community. He stated he interacts with nurses approximately weekly, mainly in the emergency department.

LE 3

LE 3 described having an Associate of Science and obtained a Master's in Mental Health Counseling through the Sheriff's department. They described staying in their career because they love to be around people. They described interacting with nurses several times a week, particularly bringing patients in acute mental health crisis to the emergency department.

LE 4

LE 4 described becoming a probation officer after a corporate career in which he did not enjoy sitting at a desk. He stated he wanted to be the change that he wanted to see in the community and put "boots on the ground". He stated he stays in law enforcement because it offers an opportunity to be a critical thinker and lead from the front. He stated that he interacts with nurses in the hospital 3-4 times a month.

LE 5

LE 5 stated he joined law enforcement because of the money, and then stayed because his work paid for him to complete his Bachelor's degree. He stated that he decided to stay in law enforcement because he enjoyed it and was "extremely surprised". He stated he was surprised because growing up as an African American, he did not have good interactions with the police. He now tries to change the image, and enjoys getting people off the streets, short chases, and helping the less fortunate. He interacts with nurses in the hospital at least a couple of times a week.

LE 6

Prior to becoming an officer, LE 6 was a social worker, and stated she got tired of sitting at a desk. She stated she enjoys being a police officer because it is never a dull moment. She shared that despite often being frustrated about politics, she still loves being a police officer and would never go back to being a social worker. She stated she interacts with nurses in the hospital at least once or twice a week because a person she has detained has been injured.

LE 7

LE 7 states she became a law enforcement officer because she wanted to change the way that law enforcement interacts with the community. She shared that she was not able to make that change, and that the community disrespects law enforcement and law enforcement disrespects the community, but she stays in it because she feels like she can make a small difference with even one person. She stated she interacts with nurses in the hospital at least once a week, usually for patients having "mental breakdowns".

LE 8

LE 8 stated that she joined law enforcement after the post 9-11 economy left her looking for work. She was previously a paralegal. She was also drawn to law enforcement because of a desire to help the community and her Christian faith led her to want to serve. She stated that despite the current political system, she still feels there is a need to help, and if she can help someone, she feels that she has done her job. She states that she interacts with nurses in the hospital weekly, usually because a person who is detained is injured or needs medication.

LE 9

LE 9 stated that she was a paralegal, and her goal was to go to law school. She stated she did not want to be a police officer, but was told by a family member they would pay for law school. She stated she was a single mom and needed a job with good benefits. She stated she did not go to law school, but did get a Master's degree. She stated that despite what people see from the outside, it is a good career. She stated she interacts with nurses in the hospital several times a week.