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Original Article

ROUTINE AND THE LABOR ORGANIZATION OF HEALTHCARE WORKERS IN A BRAZILIAN FEDERAL PRISON

COTIDIANO E ORGANIZAÇÃO LABORAL DE TRABALHADORES DE SAÚDE EM PRESÍDIO FEDERAL BRASILEIRO

DÍA A DÍA Y ORGANIZACIÓN LABORAL DE TRABAJADORES DE SALUD EN PRESIDIO FEDERAL BRASILEÑO

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Objective: analyze the work's organizational routine of healthcare professionals in a federal prison, and its influence on the health of these workers. Method: qualitative exploratory study with six healthcare workers holding permanent labor contract with the institution. Data from semi-structured interviews were analyzed according to the thematic content. Results: the results were grouped in the following thematic categories: The routine of healthcare professionals in a federal prison work, and The health work organization in a federal prison: task distribution, low control, and its influence on the workers' health. The form of work organization of a prison creates anxiogenic situations inside and outside the workplace. The work was characterized as bureaucratic, with no autonomy, and permeated by fear and alertness. Conclusion: the healthcare professionals working in a federal prison perceive the activities developed as stressful, frustrating, and demotivating, which could trigger a work-related illness process.

Descriptors: Prisons. Worker's health. Working conditions. Health personnel.

Objetivo: analisar o cotidiano organizacional do trabalho de profissionais da saúde em uma penitenciária federal e a sua influência na saúde desses trabalhadores. Método: estudo exploratório qualitativo com seis trabalhadores da saúde com vínculo efetivo na instituição. Os dados oriundos de entrevistas semiestruturadas foram analisados de acordo com o conteúdo temático. Resultados: os resultados foram agrupados nas categorias temáticas: O cotidiano dos profissionais da saúde para o trabalho na penitenciária federal e A organização de trabalho de saúde na penitenciária federal: divisão de tarefas, baixo controle e sua influência na saúde do trabalhador. A forma de organização de trabalho da penitenciária gera situações ansiogênicas dentro e fora do ambiente de trabalho. O trabalho foi caracterizado como burocrático, sem autonomia e permeado por medo e estado de alerta. Conclusão:

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os profissionais da saúde que trabalham em uma penitenciária federal percebem as atividades desenvolvidas como tensas, frustrantes e desmotivadoras, podendo acarretar o seu adoecimento pelo trabalho.

Descritores: Prisões. Saúde do trabalhador. Condições de trabalho. Pessoal de saúde.

Objetivo: analizar la organización laboral cotidiana de profesionales de salud en penitenciaría federal, y su influencia en la salud de los trabajadores. Método: estudio exploratorio, cualitativo, con seis trabajadores de salud con relación de dependencia institucional. Datos recolectados de entrevistas semiestructuradas, analizados según contenido temático. Resultados: los resultados fueron agrupados en las categorías temáticas: Día a día de profesionales de salud trabajando en penitenciaría federal, y Organización del trabajo de salud en penitenciaría federal: división de tareas, bajo control e influencia en la salud del trabajador. La forma de organización del trabajo en la penitenciaría genera situaciones ansiogénicas dentro y fuera del ámbito laboral. El trabajo fue descripto como burocrático, sin autonomía y signado por temor y estado de alerta. Conclusión: los profesionales de salud actuantes en una penitenciaría federal perciben las actividades desarrolladas como tensas, frustrantes y desmotivadoras, pudiendo derivar ello en padecimientos por el trabajo.

Descriptores: Prisiones; Salud Laboral; Condiciones de Trabajo; Personal de Salud.

Introduction

Working under the capitalist system, given its centrality in human life, generates values resulting from the living work. Therefore, populations should be submitted to specific organization principles, characterized by increased production and gain of capital, as well as intensive exploration of the labor force and loss of job security. This is a conflict that structures social relationships and strongly influences workers' health[1-2].

Despite technological advances and new organizations, the painful work has not been extinguished since social inequalities were sharpened and brought another type of suffering much more subtle and complex: mental problems[3].

Work organization[4] is conceptualized as the distribution of both tasks and manpower. This concept comprises an individual's responsibilities at work and its execution, relationships of power, hierarchies, a worker's degree of autonomy, in addition to the possibility of employing subjectivity, innovation, cooperation, and communication. These resources and skills, when consonant, are beneficial to the work organization and to workers. However, when these processes are flawed or inefficient, they play a core role in understanding workers' illness processes.

In an attempt to understand the psychical dynamics in face of the conflicts ensuing from the confrontation between the working subject's desire and the work management models, the work psychodynamics comes about, explaining that suffering at work is inherent to every experience in this labor[2-3].

The prison work organization is typically depicted in a derogatory and stigmatizing way, besides being considered risky and stressful[5]. Therefore, the work of healthcare professionals in this context deserves great attention since it has to cope with prejudice, difficulties, and labor limitations ensuing from the confined workplace environment. In this sense, this paper investigated the organization and context of working in a federal prison, and the healthcare laborers working in this environment.

Federal prisons - five units in the country - differ in many aspects from the common prisons under the custody of the states: they were built following the structural prototype of the supermax American maximum security prisons, they are administered by the federal government and intended for high-risk convicts and leaders of criminal factions who, during their stay in state prisons, have placed order and public safety at risk[6]. Because of these features, the resocialization and care activities developed

with prisoners are much more limited, and health activities differ from those in external environments, and even from those in state prisons.

According to a study[7] carried out with different workers in maximum security environments, healthcare professionals were the most intensively affected by occupational stress. Direct care to prisoners has increased these workers' risk of disease in comparison with other staff members, added to psychological suffering resulting from the situations of violence and high rate of suicide among the assisted audience[7]. Studies also disclose that work organization arrangements in custody environments that prioritize security-related issues in detriment to health-related issues lead healthcare professionals to uneventfully face ethical questions, since the application of their work is very constrained[8-9].

A literature review shows studies that approach aspects related to organizational structures in the Brazilian state prisons. In this regard, there is evidence of daily risks involving prison guards of state institutions such as unhealthy working conditions, pressure, and demands imposed by the state. In addition, there is a lack of psychological support to workers[6]. Regarding healthcare professionals working in prisons, a relevant aspect is the overload of activities due to the great human resources gap[8-10].

In this sense, it is worth mentioning the inexistence of studies addressing healthcare professionals in the Brazilian federal prisons. Generally speaking, health in prisons is a phenomenon disregarded by the Brazilian literature. And the few existing studies focus on health complications found in prison[11] and in state realities.

The salary conditions offered to health workers in federal prisons are above the average of those offered in various health workplaces, in addition to the stability factor because it is a public job. Nonetheless, the professional practice of one of the authors of this investigation shows that, in the scope of a federal prison, professionals remain remarkably stressed and unmotivated. It was in this light that emerged the interest in understanding what happens in the routine of this work, how it is organized, and how such dissatisfaction can arise from the organizational structuring and the routine work.

Therefore, routine is understood as what is presented or is shared on the everyday work. These are trivial practices of individuals that, even denoted as a set of ordinary activities, stand for a very rich field influenced by social rules and conventions[12]. In this aspect the routine emerges as a space of continuous stress, crossed by disciplinary institutions, and different cultural practices[13].

Considering this reality the following questions came up: How is the everyday routine of healthcare laborers working in a prison? How are their tasks divided? Is there any autonomy? How could work influence their health?

This study focused on the workers' health and intends to collaborate with elements to understand the relation between the labor world in Brazilian prisons and the consequences to the health of workers working there, mainly healthcare workers.

Therefore, the objective of this study was to analyze the organizational work routine of healthcare professionals in a federal prison, and its influence on their health.

Method

This is an exploratory study of qualitative approach. This kind of study considers a reality level that cannot be quantified, involves a universe of meanings, reasons, aspirations, beliefs, values, and attitudes, and also allows deepening the understanding of the human reality socially experienced[14].

This study results from the excerpt of a course's term paper of specialization in public health from the Western Paraná State University (UNIOESTE), Brazil. Interviews were conducted by one of the authors who, besides being a researcher, was also part of the health staff in the prison analyzed, a federal maximum-security prison in the state of Paraná. The interaction and proximity of the researcher with the researched

subject facilitated the approach and the progress of the research.

The Brazilian Federal Prison System (FPS) studied was implemented in 2006, but only in 2009 the positions of prison assistance expert and technician of support to prison assistance were established. The position of expert is directed to higher education professionals from the fields of health and education, such as: physicians, pharmacists, nurses, psychologists, dentists, occupational therapists, social workers, and pedagogues. The technical staff, made up of nursing technicians and dentistry assistants, must hold secondary education with technical training[15].

The healthcare professionals, i.e., experts and technicians, were personally invited to participate in the study. All items of the Free and Informed Consent Form, the research objectives, data collection procedures, and assurance of anonymity were explained. Those who accepted to participate defined the date and place of meeting, and all of them preferred to meet at their homes because they considered them a reserved environment.

The criteria to include participants in the study were: working as a healthcare professional, having at least six months of experience in the activity, and being a permanent employee.

Therefore, in the scope of 11 healthcare professionals from this location, six workers participated in the study, of which four were experts in prison assistance (one nurse, one psychologist, one pharmacist, and one dentist) and two technicians of support to prison assistance (one nursing technician and one oral health technician). Two professionals refused to participate in the study. One claimed to feel uncomfortable being exposed in the study, despite the assurance of anonymity; and the other, because, during the execution of the interviews, asked to be exonerated from the prison work to take up employment in another public job located in the home state of this person. One researcher and one professional who answered a preliminary interview to test the data collection instruments were also excluded from the group. The test application allowed the analysis of results, while the required adjustments and reviews of the instrument were made.

Data were collected using semi-structured interviews, which lasted about 30 minutes and were recorded and fully transcribed. The number of respondents was established through the repetition process, which ceased when the collected data became repetitive and allowed understanding the phenomenon under study. Most of the respondents were women - four; their age ranged from 28 to 44 years, and marital status reported was proportional between single and married respondents. Participants were identified by the letter "D" followed by a sequential Arabic number to ensure the anonymity of speeches.

The analysis *corpus* was made up of the material transcribed from records, employing the modality of thematic content analysis, developed in three stages. The first stage was to get acquainted with the material gathered, through readings and re-readings. In a second stage, information was coded, identifying statements and topics. In the third stage, the coded material was grouped according to the similarity of topics and the objectives of the study[14]. It is worth mentioning that the identification of the thematic units related to the organization and routine of health work in the prison considered the respondents' testimonies. For the purposes of this study, work organization is not restricted to the work distribution but is mainly related to the distribution of tasks and men[4].

The study was approved by the Research Ethics Committee of the Western Paraná State University (UNIOESTE) under Protocol n. 167/2011. The research followed the ethical guiding principles provided for the Resolution 196/96 which regulates research with human beings.

Results and discussion

The female preponderance observed in the present study is aligned with the phenomenon of a greater insertion of women in work outside home, even in areas and workplaces where men

are dominant such as police, security, prisons, and engineering. However, despite the official discourse of gender neutrality, some informal jokes and comments exclude women and mark the gender difference[16].

In masculine environments the expected behavior is that socially performed by men, i.e., use of force and reprehension, and the consistent need to affirm virility. Thus, activities with assistential character and with a predominance of female workers, such as those in the health sector, are little appreciated[17].

A study performed with female prison guards showed that women report more stress associated with the work in prisons than men, maybe due to cultural reasons, for being more vulnerable to stress at work, with less physical resources to respond to violence, and greater difficulty to impose themselves as authority, as well as the need to establish themselves as competent professionals in such environments[18].

In reaction to the activity developed, the interviewed healthcare team reported that the federal prison was not their first job. Two (33.33%) respondents had previous experience in municipal government jobs; one (16.66%) with a state government job; one (16.66%) with a federal government job; one (16.66%) in the private initiative; and, one (16.66%) in at-will government labor. To take on these positions, the discourses showed some aspects inherent to the work, as described below.

> *Stability, fixed payment, some guarantees I didn't have when I worked by myself.* (D1).

> *The fact of being a federal civil servant, but, above all, the salary, because with the technical course I have, I do make good money here. It's because I'm a technician and, to my level, here is where we earn more.* (D6).

> *Actually, I came to that job by chance [...] I didn't decide it, but it was an option and I went there, was approved and here I am.* (D6).

These motivations support the finding that the professional decision of those responsible for prison surveillance is due to the need for making a life, and disregards the individual's will. According to some studies with prison guards, the motivations to work in a prison were: relative feeling of stability in the job; being a civil servant; and the wage that, in the national context of high levels of unemployment, and compared to other government positions, pays bonuses that are added to the final amount[18-20].

The discourse analysis allowed the elaboration of two categories: "The routine of healthcare professionals in the federal prison work" and "The health work organization in the federal prison: task distribution, low control and its influence on the workers' health." Moreover, it allowed brainstorming the day-to-day work of healthcare professionals in a prison.

The routine of healthcare professionals in the federal prison work

The prison analyzed is in an inland municipality of Paraná, Brazil, with nearly 10 thousand residents. The Federal Prison System project aims to isolate the main leaders of criminal gangs and highly dangerous prisoners, jointly with a proposal of more humanized custody. To ensure that prisoners serve their sentence, deprived from the freedom of movement but with rights such as health, the FPS relies on a multiprofessional healthcare team to meet the health needs of its population.

To get to work, laborers travels about 90 km everyday because they live in a different municipality, 45 km far from the prison; which offers better quality of life, and infrastructure such as hospitals, daycare centers, leisure, and culture. They organize carpooling and drive on a quite busy highway with traffic of vans, cars, and trucks. The respondents evaluated this aspect as *dangerous*, due to the high index of traffic accidents on the home-work-home journey. This is, *per se*, an anxiogenic fact, according to the following testimonial:

> *The highway is very dangerous, hitting the road everyday. We have seen lots of accidents on our way to work.* (D3).

The studied prison has very strict security rules to minimize control failures that could cause corruption and the practice of illegal acts. On behalf of the security, healthcare workers, just

like all other workers, undergo processes and procedures when they get to the prison, such as screening by walk-through metal-detection equipment and X-Ray machines. These devices are adjusted to be more sensitive to metals than those used in airports. In the FPS any employee circulating with metals, cell phones or any other material that could be eventually used by any prisoner may suffer disciplinary sanctions and even be dismissed.

> *There is a person [guard] on each gate and metal-detection devices* […] *I felt somewhat downgraded, thinking that was because they were distrusting me. Today I know this is very important, to go through this, if tomorrow or after there is any problem I have been checked, they won't suspect of me.* (D1).

The intensive watch through metal-detectors and surveillance cameras is a way of exercising the disciplinary power, with no physical punishment, in the prisons. These technologies induce among prisoners a conscious and permanent state of visibility, conditioning them to behave well since they know they are being monitored[13].

This monitoring, however, branches into the micro-sites, being transmitted among the many individuals. Therefore, it may also concern the workers working in there, as can be inferred from the discourse above in which the worker feels the need to prove their honesty. This brings about an atmosphere of intensive demand on the subject[13].

Surveillance clearly shows the power of visibility that, in turn, stands for one of the main forms of power relations in the everyday of a disciplinary society, shaping attitudes and behaviors[13]. Consequently, workers undergo the same ritualization of the symbolic value as the prisoners, since they must follow the same rules and are likewise isolated from the outdoors environment, even if temporarily[21].

Health work organization in the federal prison: task distribution, low control and its influence on the workers' health.

The health sector workplace in the FPS is equipped with: a room for medical care; an outpatient care unit equipped for small surgeries; a dental office; a ward with three beds (for small interventions such as serotherapy); a psychological care room; a pharmacy; a sterilization room; and three cells on the back to keep up to three prisoners under medical review. The physical and equipment infrastructure is aligned with the recommendations by the penitentiary policy[22].

When a prisoner enters the prison, he or she passes by the health sector where they receive care by a multiprofessional team, pass by a triage, are submitted to blood exams to control and evaluate their health and find pre-existing or infectious-contagious diseases, vaccination, controls (high blood pressure and diabetes), among others. Further appointments, except for urgency and emergency care, are requested by the prisoner through a communication tool named "requirement". Any conduct or displacement in the prison is mediated by a prison guard, including for the delivery of health care. To perform the health service required, healthcare workers stay at the prison security sector facilities, as disclosed in the following statements:

> *I get there and I plan the services, I request, check the possibility of having guards to take the prisoners to the health service, if the prisoner can be taken to the office, I provide the care.* (D1).

> *I get there and prepare a list of consultations. Before assisting them, I check with the security management if there is any guard so I can deliver the care.* (D3).

Therefore, the healthcare workers ask the heads of the socialization areas (galleries) to take the prisoner to the health sector. Throughout the consultation, the prisoner remains handcuffed and is escorted by at least two prison guards.

There are countless difficulties to develop health actions in prisons, since these are spaces that prioritize punitive practices[11]. A notorious safety measure of the SPF is to avoid unnecessary exits of the prisoner to the external environment, so as to reduce the chances of escape or exposure of guards, healthcare professionals (who often accompany the escort of the prisoner to a hospital, for example) and the population.

Therefore, if the prisoner's pathology demands more specific therapy outside the prison environment, the healthcare professionals must motivate and support the referral.

There is no permanent physician in the institution's staff. Healthcare is provided by a physician hired to work in the prison, but contracting is not always possible. The absence of that professional hinders the health sector dynamics and directly affects the nurse for the higher exposure to the prisoners' inquiries and demands, resulting in overload of requests and claims. Besides being the link to the medical care, nurses are the professionals that interact more closely to prisoners since they deliver medications three times a week, from cell to cell, monitor blood pressure, blood sugar, collect blood, and perform other procedures.

It is widely known that prison population demands more medical care than the non-imprisoned population, since the prison environment favors higher incidence of health problems. The stress related to imprisonment, unhealthy conditions, significant number of cases of STD/AIDS, tuberculosis, pneumonias, dermatoses, hepatitis, as well as mental disorders and higher risk of suicide are some of the occurrences[23-24].

According to the penitentiary policy, the minimal healthcare team of prisons with more than 100 prisoners, as happens with the prison object of this study, should be made up of: a physician, a nurse, a dentist, a psychologist, a social worker, a nursing aide and a dental aide, working 20 hours a week. To the prison facilities that already had healthcare staff, the team would be complemented[22], even if the place spends long periods with no continuous assistance by a general practitioner and a psychiatrist. Therefore, the prescription of psychotropic drugs, the monitoring and the performance of practices to assist those suffering from drug or alcohol withdrawal are impaired, which is not in line with the healthcare policy to this population.

Pharmacists have technical support to analyze the medication prescription, proper administration mode and route, ensuring the right and safe use of medications. They prevent medication errors and enhance the quality of care delivered to patients and the safety of drug therapy[25].

In the penitentiary context, the professional pharmacist controls the medication stock, carries out the procurement procedures and medication orders, assists the physician about the standard medications in the prison and those allegedly unsafe in that environment. Among other tasks, they prepare a medicine organizer box that is delivered to the prisoner by the nursing professional. This box is identified with the name of the prisoner and the medication, as well as the respective time schedule[25].

The nursing professional gives the medication box to the prisoner, in the socialization space, jointly with the security sector agent. The activity demands permanent attention to avoid that any medication container could be used as a weapon and cause any damage to either the integrity of the own prisoner or of other inmates, as well as the workers. In this sense, before leaving any material or medication with the prisoner, these must be evaluated and authorized by the security sector.

Another relevant aspect is the shortage of professionals that causes accumulation of functions as disclosed in the following discourse:

> *There should be more professionals. It is very hard to have one single psychologist, one single dentist. The staff could be bigger.* (D3).

The shortage of workers should be added to the aspect of workload. The policy that rules health care in prison environments recommends 20 working hours per week[22]. Although the law that governs job positions in the FPS provides for 40 working hours a week in full-time regime (8 hours a day) or on-duty regime (24 hours of work followed by 72 hours of rest)[26]; in practice most of the expert and technical civil servants work in full-time regime and daily direct contact with prisoners. The nursing team is the only one working in on-duty regime.

> *Going there every day is really stressful. It is a heavy workload. Lots of negative energy. 40 hours is too much.* (D5).

According to the respondents, the pace of work was directly related to the availability of the security officers to take prisoners to receive health care in the health sector or to go with the professional to their cells:

> *It depends. Some days are very busy and others are very calm.* (D3).

The lack of systematization and routine of the tasks causes the work to acquire an improvisation character; which implies both difficulties in its execution and exposure to criticism and / or reprisals by the prisoner himself, people from other sectors or even from the professionals themselves[19].

The healthcare team interviewed considered the lunch break as a moment of relaxation. Perceived as an opportunity to enjoy the interaction with fellows in a different situation from that of their everyday work reality, which is marked by a linear and uneventful time with an organization that prevents deep contacts, personal matters in front of the prisoners, and that demands reservation and alertness. Hence, when opportunities to briefly escape from the slaughtering routine emerge, danger is despised, momentarily disguising fears and risks. This is a defense mechanism required by the workers' productivity in hostile workplaces[27].

> *We make a point of eating out of the penitentiary. Trying to detach from that environment.* (D2).

Another factor observed was the way work is organized. The respondents formally reported directly to the director and to the chief of health in the prison, and informally to the security distribution since they needed at least two prison staff members, of which at least one security agent, to perform any procedure with the prisoner. The following speech illustrates it:

> *I guess there is not [autonomy], it depends a lot on the security. In our contact with the prisoners we need them, there is no direct contact with them, an agent must always accompany us.* (D2).

The subordination to other hierarchical levels implies the need to report to different individuals to carry out the work. However, the managerial positions are not always occupied by people with the same education as the subordinates. In an environment where security is crucial, the director position is usually held by a security agent. This can hinder raising awareness on health-related issues.

Some studies report that low control over work impairs reaching the healthcare goals formally prescribed. In the prison scope, the actors committed to granting access to health care face lack of autonomy and dependence on the security work, which sometimes reduces their practice to complementary roles, hindering decisions, hampering the freedom of action, and impairing the control of tasks by workers. Therefore, it can lead workers to the diseasing process[28-29].

Another relationship that should be considered is the one between healthcare workers and the population served in the prison. While in other environments the healthcare worker endeavors to establish an empathetic relation with users, in a federal prison they try to keep distance and impartiality, focusing attention on the pathology and avoiding any link, regardless if related to animosity or friendship. According to respondents, this is because this relationship is permeated by challenges and demands, as illustrated in the speech below:

> *The convicted person is a hard client to deal with. They argue too much, are full of rights, shout, all we do is never enough, they want to take the drug they want, want to demand a lot.* (D5).

In a prison, small everyday practices may cause unwillingness between the convicted individuals and workers, such as a demand for a given drug or service from the interdisciplinary team. Moreover, the prison environment is marked by oppression since it is focused on the social control of popular classes. In this degraded social environment, fear and violence are part of the routine. Workers interviewed in a state prison referred to prisoners as people deprived of discipline and respect, endowed with lots of rights because of flawed laws, impunity and lack of justice[19].

This evidences the workers' worry or fear regarding the clients served, as reported below:

> *This situation is very sensitive. We must recall all times who they are, what they are capable of doing.* (D1).

The fear of attacks to their physical integrity, feelings of concern, fear for the exposure of their families and the feeling of being in danger are some of the anxiogenic experiences that cause suffering and the likely illness process to which prison workers are subject. The exposure to psychosocial risks resulting from stress and violence make them be always alert, either in activities within the walls of the prison, or in outdoor activities developed in an individual, family or social way[20]. The following report is a good illustration:

> *Many will not be confined for life. They will be set free and if they felt they didn't like someone, they have nothing left to lose, right?* (D4).

Regarding the relationship with agents and health peers, the respondents consider it friendly and healthy. In this sense, a labor context that adopts more respectful and friendly relationships between teams reduces the different modalities of violence (psychological, institutional, physical and sexual) that exist in the work institutions, as well as discriminatory conducts. This collaborates to a healthy subjectivity between professionals and the other actors involved[30]. This is evidenced in the following excerpt:

> *My friends are from work. Most people in my workplace also came from other places, I have no family here. So, we get together and build a family.* (D1).

Studies have found that fear, stress, consistent exposure to danger, and a repressive environment can raise the rates of physical diseases and mental disorders, increasing the number of leaves and absenteeism in work. The main diseases found by these studies among workers in the criminal area are gastritis, headache, depression, feeling of "being over", insomnia, stress, and chronic fatigue[18-20].

The healthcare worker's conduct in the penitentiary environment should also be staying alert in relation to their technical procedures, since this implies refitting their professional practices to make them more responsive to the environment. Any conduct by the worker regarding the prisoner's health care is only made after the security unit analyzes the likely risks and evaluates the procedure as applicable and safe. This practice, however, clashes with that learned during their professional training. Therefore, healthcare professionals face the dilemma of the detachment between academic training and professional experience.

A behavioral factor that affects workers is a process known as "*prisionalization*", understood as the assimilation of the prison culture, characterized by the local language, way of thinking, uses and habits typical to the prisoners. This leads to conflicts of values, considering that workers carry values of the free society that are different from those values built inside the system. Such ambivalence requires from workers adaptive skills to ensure their survival in the system. This, however, brings stress to the individual caused by the repression of feelings and control of aggressiveness[28]. Therefore, anyone who enters a prison system, whether a prisoner or a worker, is somehow subjected by the organization, operation, and situations of risk experience in that place[27]. The same was true to the population studied.

The analysis of the everyday and the work organization in the studied federal maximum security prison disclosed some singularities and organizational situations that affect the workers' health. The surveillance system, for example, not only monitors the prisoner but also allows monitoring the healthcare actions, enabling the evaluation and questioning about the professional conducts adopted both by individuals internal to the prison and by those outside the prison, for instance the prisoners' attorneys. With that, the panoptic (visibility) model referred by Foucault[13] would also be replicated to workers.

The healthcare team work is developed with low level of control due to the hierarchical subordination and dependence on the security unit, even in aspects exclusive to the profession; low decision-making power and poor appreciation of workers in the work management process; bureaucracy; lack of software implying in activities of artisanal nature; accumulation of

functions; shortage of professionals; improvised work routine and inconstant and dependent work pace; long workload; and, constant climate of alertness, stress and fear.

The trivialization of violence, which is considered a commonplace in these places, make the professionals working in prisons ill, and does not rehabilitate any imprisoned individual who experiences such phenomena everyday. In these sense, these phenomena are reflected in the society because the imprisoned individual who lives such adverse situation is likely to take this hostility out of the prison walls when she or he leaves prison. Hence, the illness process that affects workers mirrors a confining model that has disregarded this issue.

Surely there are many issues to be explored to advance knowledge about the repercussions of the healthcare work in a federal prison. The remarkable shortage of studies about healthcare professionals working in full organizations, such as prisons, becomes evident when the topic is health care in prison. The existing studies typically focus on the diseases that affect the imprisoned population, leaving aside the caregivers' health.

This study is expected to contribute to expand the knowledge about existing issues in the healthcare work in a prison, as well as to demystify it, since it is largely unknown to the other healthcare professionals and to society. Through the appropriation of knowledge and awareness about the problems, managers, politicians, healthcare professionals and society can engage in the search for a solution to historical challenges regarding the working conditions in prisons and assistance to prisoners.

The limitation of this investigation regards that it was carried out in one single prison, reducing the number of participants. Thus, further research should be carried out involving other prisons, in order to allow comparisons and likely generalizations that provide inputs to better ground and to expand the analysis.

Conclusion

The work's organizational routine of healthcare professionals in a federal prison contributes to their low degree of satisfaction, unhappiness, and discouragement in the workplace. There is fear in relation to the population served and of being challenged inside and outside the prison boundaries. The daily struggle with different forms of violence results in emotional distress which is minimally mitigated by the good relationship with workfellows.

Management cannot disregard the violence that participants experience in the workplace. The adoption of measures to promote health and prevent the worker's health problems, as much as to reduce situations of violence and exposure to these through the reduction of work hours would soften the stress load in this workplace.

Healthcare professionals working in a federal prison perceive their activities developed as stressful, frustrating and demotivating, which could trigger work-related diseases among them.

Collaborations:

1. conception, project, data analysis and interpretation: Lana Jocasta de Souza Brito and Neide Tiemi Murofuse;

2. article writing and relevant critical review of its intellectual content: Laura Adrian Leal;

3. final approval of the version to be published: Silvia Helena Henriques Camelo.

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