A Call to Stop Shackling Incarcerated Patients Seeking Health Care

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Abstract

Incarcerated people are often shackled while seeking health care simply because of their criminal legal status. (In this statement, we define incarcerated people as those whose health care access is determined by the criminal legal system. This may include people in custody of local, state, territorial, federal, or other criminal/legal facilities [jail, prison, and other detention]; people detained by U.S. Immigration and Customs Enforcement [ICE] or in ICE detention centers; people detained in medical facilities or other locations as a result of legal or executive order or ordinance; people detained under community correctional supervision; and/or people held pending legal determination or adjudication of alleged charges. While we understand this is an unconventionally broad definition, our goal is to encapsulate everyone who lacks agency in their access to, choice of provider of, and/or provision of health care.) Shackling in health care settings involves physical, medical, or mechanical methods of restricting a patient's body or movements for reasons that are not clinically necessary. Although justification for shackling is typically centered around safety, shackling is a violent practice with detrimental effects on both patients and health care providers. The practice has been recognized as a human rights violation among pregnant/perinatal incarcerated people, but the same dignity has not been extended to all people incarcerated. Therefore, APHA recommends the following actions to end the practice of shackling during health care: (1) legislative action, (2) national research efforts, (3) clinical guidance, and (4) clinical practice.

Relationship to Existing APHA Policy Statements

- APHA Policy Statement 7106: Jails and Prisons—Public Health Response to a National Disgrace
- APHA Policy Statement 7315: Health Care in Jails and Prisons
- APHA Policy Statement 7921: Support for a National Strategy to Help Improve Health Care in Prisons, Jails, and Youth Detention Centers
- APHA Policy Statement 9123: Social Practice of Mass Imprisonment
- APHA Policy Statement 20048: Correctional Health Care Standards and Accreditation
- APHA Policy Statement 20201: Recommendations for Pregnancy Counseling and Abortion Referrals
- APHA Policy Statement 201310: Solitary Confinement as a Public Health Issue

- APHA Policy Statement 201311: Public Health Support for People Reentering Communities from Prisons and Jails
- APHA Policy Statement 202117: Advancing Public Health Interventions to Address the Harms of the Carceral System
- APHA Policy Statement 202119: Preventing Violations of Sexual and Reproductive Health Rights in Immigration Detention

Problem Statement

At the height of the COVID-19 pandemic, a resident in training at the Boston Medical Center performed cardiopulmonary resuscitation (CPR) on an incarcerated patient.[1] The patient was in his mid-70s and was on ventilation because of a severe COVID-19 infection. This was a familiar sight for most frontline workers, but one detail was different. The patient was shackled to the bed with a metal ankle cuff. He died shortly after, still intubated, still shackled.

Shackling during health care involves physical, medical, or mechanical methods to restrict a patient's body or movements for reasons that are not clinically necessary.[2] Although health care policy regarding incarcerated patients and shackling is inconsistent, many health care organizations have policies calling for indiscriminate shackling of those patients solely based on their criminal legal status. Some health care organizations leave shackling decisions up to correctional and law enforcement agencies, whose values directly oppose the Hippocratic Oath.

Shackles are distinct from restraints. Restraints are used on nonincarcerated hospital patients and are regulated by the Centers for Medicare & Medicaid Services (CMS), which mandates the least restrictive form of restraint be used to protect the safety of the patient, health care staff, and others.[3] Providers are required to document the reason for restraint, form of restraint, reevaluations of continued restraint need, and any consequences for patient health. In contrast, shackles are placed by correctional or law enforcement officers or security staff, who are not subject to CMS regulations. Shackles are not medically necessary and are often used "as a means of coercion, discipline, convenience, or retaliation."[4]

Incarcerated patients may be shackled across health care settings, including in care facilities operated within carceral facilities, community-based clinics such as outpatient and urgent care clinics, emergency departments, hospitals, and during transportation to or from medical encounters by custody staff and/or emergency medical staff.[5] For example, in 2021, Ankita Patil, an emergency medical technician, rode in an ambulance with a pregnant incarcerated patient. The silver handcuffs encompassing the young woman's wrists restricted her in many ways. During the height of the COVID-19 pandemic, Patil noted

that the shackles prevented the patient from adjusting her worn-out mask to cover her nose, placing everyone at risk for potential COVID-19 transmission.

It has been argued that shackling is intended to reduce flight risk, risk of self-harm, and risk of physical harm to medical providers and surrounding personnel. However, there is limited evidence demonstrating that shackles serve this purpose; these are primarily misconceptions with anecdotal "evidence." For example, in one year there were 99 incidents of incarcerated patients (both with and without shackles) escaping during transport to health care facilities or at the facilities themselves, which is extremely rare considering the size of the entire incarcerated population and the number of individuals cycling through the carceral system each year.[6] The claimed purposes of shackles primarily rely on anecdotal experiences rather than systematically documented treatment and the effects of shackles on incarcerated people receiving health care.

Despite this sparse evidence base, many health care organizations either have policies that call for shackling incarcerated patients by default or lack protections against shackling by correctional staff. Indiscriminate shackling policies result in cases of patients being shackled in a range of circumstances, including during pregnancy, labor, surgery, end of life, and restricted mobility. Shackling in such circumstances is cruel and inhumane because it harms patients who are already extremely vulnerable due to illness, physical ability, medical status, and/or age.

In 1976, the Supreme Court of the United States ruled that willful neglect of serious medical needs was a violation of the Eighth Amendment right to be free from cruel and unusual punishment. Since then, federal courts have condemned shackling of incarcerated pregnant patients as a violation of the Eighth Amendment.[7] In 2006, the United Nations Committee against Torture criticized the United States for shackling pregnant incarcerated patients, deeming it a violation of Article 16 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[8] Based on these precedents, indiscriminate shackling policies violate constitutional and human rights.[9] Any human rights violation is a public health issue, and this one has a large population at risk: 5.5 million people.[10]

According to a 2023 Prison Policy Initiative report, approximately 2 million people are incarcerated in the United States, while 2.9 million people are on probation and 770,000 people are on parole.[11] Of those currently detained, 34,000 are in immigrant detention and 619,000 are in jails. It should be noted that jails typically detain people pretrial and convicted individuals whose sentence is less than 12 months. Therefore, the total estimate for incarceration does not account for the volume of people cycling in and

out of jails. For example, people went to jail 7 million times in 2021. Indiscriminate shackling policies therefore place millions at risk of harms associated with the practice.

Shackles cause extreme harm in various forms: Negative health outcomes of shackling include a breakdown of the skin and damage to surrounding structures leading to severe bruising, abrasions, lesions, fractures, neuropathies, ulcers, infections, scarring, lacerations, and injuries to the ulnar, radial, and median nerves.[6,12,13] Shackles can also cause extreme risk of injury due to limited mobility and forced limb movements that predispose incarcerated people to falls and thrombosis.[6,14]

Shackling also increases risk of emotional harm as it erodes trust between patients and providers.[15] Evidence shows that shackles can reinforce existing negative biases toward incarcerated patients, setting the stage for inappropriate use of force by health care staff and security personnel.[16–19] Patients who experience discrimination and perceive stigma due to their criminal legal status are more likely to have poor health outcomes.[20] The harms of discrimination are intertwined with issues of race, as people of color—who are overrepresented in the incarcerated population—are less likely to trust their providers.[20] Shackling thereby further damages the strained relationship between incarcerated patients and their health care providers. Incarcerated patients may view their provider and/or hospital as complicit with shackling, and providers may act on internalized biases when treating shackled patients.

The effects of perinatal shackling (shackling during pregnancy, labor and delivery, and the postpartum period) can also cause extreme hardships for both child and parent. Adverse effects include increasing a pregnant person’s risk of blood clots and hemorrhage, hypertension, preterm birth, and labor and delivery complications such as abdominal trauma and risks to the fetus itself.[6,15,21–23] Shackling also increases risk of falls or injury throughout pregnancy, which can lead to abruption and fetal death. Furthermore, shackling can impede the processes of labor and delivery, hinder emergency obstetrical care, and interfere with postpartum recovery, including the mother’s ability to safely hold and breastfeed her infant.[24] Separation of infants from parents can lead to extreme behavioral and emotional problems for the child, such as low self-esteem, poor coping skills, depression, anxiety, anger, and psychiatric disorders, as well as psychological trauma for the parent and family.[23,25] Shackles can also cause severe trauma among incarcerated juveniles and children, including physical injury and psychological and emotional harm.[26]

Shackling undermines providers by decreasing their autonomy and may result in suboptimal care. Deshackling patients is often up to correctional officers rather than providers. Common challenges providers face when caring for shackled patients include shackles interfering with examinations and

surgery; difficulty upholding the incarcerated patient's dignity, overall comfort, and right to privacy; and trouble communicating and interacting with guards who have been described as cruel and intrusive by participants of some studies.[15,16] In one of the most striking examples from the literature, providers reported that shackles limited their ability to provide dignified care at the end of life.[27]

Shackling in health care settings could also contribute to health care staff moral injury. Moral injury is defined as harmful long-term emotional, psychological, behavioral, spiritual, and/or social effects that result from acts that transgress one's moral beliefs and expectations in a high-stakes environment.[28] Health care staff may experience moral injury when they are required to treat shackled patients because it violates the Hippocratic Oath and has been deemed cruel and unusual punishment. For instance, evidence suggests that shackling poses unintended risks to health care workers' psychological well-being.[15,16] Preliminary results from qualitative interviews conducted in 2022 showed that workers in health care settings report significant distress from witnessing critically ill patients being handcuffed or otherwise restrained to their hospital beds.[29] As such, shackling affects the ability of health care staff to provide high-quality, dignified care and healing.[15,16,27]

Shackling's disproportionate harm: The U.S. carceral system, which reflects the disproportionate incarceration of historically targeted racial and ethnic groups, is one form of structural racism. Black, Latinx, and indigenous populations are policed and incarcerated disproportionately and, on average, enter the criminal punishment system at younger ages than their White counterparts.[30] A distinct majority (67%) of those in state prisons, which incarcerate more than 1 million people, are persons of color: 33.3% Black, 20.4% Hispanic, 11.1% two or more races, and 2.3% Native populations.[10] This racial disparity is by design, both in what constitutes a crime and how such laws are enforced.[31] When compared with the general population, in which 43% of individuals identify as people of color, the racist nature of U.S. criminalization becomes clear.[32]

Incarceration is inherently traumatic[33]; research has revealed elevated rates of traumatic events and posttraumatic stress syndrome among incarcerated people, some of whom experience health care–induced trauma.[34–36] This trauma and its resulting negative health impacts (both physical and mental/emotional) extend not only to the people incarcerated but also to their children, families, and communities.[37] Studies show that people who are incarcerated experience a 2-year decline in their life expectancy for each year they are incarcerated.[6] This may partially explain why the life expectancy of African Americans, who are overrepresented in the criminal legal system, is 6 years shorter than that of White Americans.[38]

Such disparities are also found among people detained by U.S. Immigration and Customs Enforcement (ICE), who report worse physical and mental health outcomes after release than before incarceration.[39] For example, immigration enforcement has been shown to be correlated with mental health issues, low birth weights, and a rise in risk factors for cardiovascular disease.[40] ICE routinely uses electronic shackling (commonly referred to as “ankle bracelets” or “ankle monitors”). In 2021, 31,000 people were shackled under ICE’s Intensive Supervision Assistance Program.[41] Electronic shackles are often portrayed as an alternative to detention,[42] which may be a response to increased political mobilization against mass incarceration. However, these shackles expand the reach of government supervision and have profound negative impacts on people’s physical health (aches, numbness, swelling) and mental health (anxiety, sleep disruption, suicidal ideation).[43]

The life derailments associated with incarceration, along with institutionally sanctioned discrimination based on criminal record, create cycles of reincarceration that impact individuals, families, and communities. In addition, incarceration reinforces racially structured access to resources such as education, employment, safe housing, and health care.[44] Many incarceration protocols have racist roots that can be traced back to the subjugation of enslaved workers and indigenous people.[31] Shackling is an example of such racist practices that further harm a disproportionately affected population while contributing to racialized barriers to health care.

Incarcerated people report having significant physical health needs relative to the general population. In 2016, for example, approximately 33% of incarcerated people reported having a chronic condition.[45] The incarcerated population is also aging: approximately 10% of individuals in state prisons are 55 years or older and are therefore particularly vulnerable to damage of the skin, fall injuries, and chronic conditions.[27,46,47] If current trends continue, more than 400,000 incarcerated older adults will be living in the carceral system by 2030.[27,47]

Furthermore, a disproportionate number of people suffering from mental health conditions are placed in carceral facilities.[47] While nearly 21% of adults in the United States have experienced a mental health illness (as of 2020), rates are astronomically higher for incarcerated individuals: 64% of those in jail, 54% of those in state prisons, and 45% of those in federal prisons report mental health concerns.[48] These demographics demonstrate that the health needs of incarcerated people make them particularly vulnerable to physical and emotional injuries associated with shackling.

Improving anti-shackling protections: Organizations such as the National Commission on Correctional Health Care,[24] the American Medical Association,[21] and the American College of Obstetricians and Gynecologists[22] have called for the end of shackling during perinatal care. Activists have leveraged these recommendations, along with scientific evidence of the harm caused by perinatal shackling, to successfully secure bans of the practice at the national and state levels.[49] In 2018, Congress passed a bill calling on the U.S. Marshals Service and the Federal Bureau of Prisons to end the shackling of pregnant and postpartum incarcerated people. ICE has already adjusted its standards of care to discourage shackling of that population.[50,51] As of August 2023, 15 states had laws restricting shackling throughout pregnancy, during labor and delivery, in transport to a health care facility, and during postpartum recovery; 25 additional states have laws restricting shackling specifically during labor and delivery.[52] However, these laws are not well implemented or enforced. In a 2018 study, 82.9% of nurses reported that their incarcerated perinatal patients were shackled sometimes to all of the time, and only 7.4% of nurses could correctly identify their state's perinatal shackling laws.[18] This is not surprising given that a 2021 Government Accountability Office report revealed that not all U.S. Marshals Service or Bureau of Prison policies align with national guidance on use of restraints among pregnant and postpartum patients.[53] Extending shackling bans to include all incarcerated people in need of care would make the laws already in place (e.g., protecting perinatal incarcerated people) easier to enforce by standardizing incarcerated patients' care.

Evidence-Based Strategies to Address the Problem

Protecting both patients and providers: Incarcerated people should never be shackled while receiving health care or en route to health care settings. As enumerated previously, the detrimental effects of shackling outweigh any purported advantages of the practice. The decision to shackle patients, and the use of correctional restraints, is not a decision made by the health care team; it is often up to law enforcement and correctional staff. Below are examples of actions that health care organizations have taken to help health care staff advocate for incarcerated patients in the absence of anti-shackling legislation.

Health care organizations: In February 2023, the Boston Medical Center (BMC)—the largest trauma center in New England and the largest safety-net hospital system in Massachusetts—adopted the first internal policy establishing routine assessments of medical conditions regarding shackling and creating a clear process for compassionate shackle removal. This policy was drafted, passed, and implemented under the guidance of the Stop Shackling Patients Coalition. Within the first 5 months of implementation, health care teams at BMC successfully deshackled an incarcerated patient through the compassionate shackle

removal process detailed below.[54] This success demonstrates that policies such as these promote justice and equity by creating clear paths for providers to advocate for the needs of their incarcerated patients. The Massachusetts Medical Society demonstrated its support of this type of policy by adopting a resolution calling for periodic assessments of patients who have been shackled by law enforcement.[55] Other hospitals have already been positively influenced by this change, and many are partnering with the Stop Shackling Patients Coalition to bring similar practices to their institutions.

The BMC policy establishes new requirements for the care of incarcerated patients shackled by law enforcement. According to the policy, nurses caring for such patients are required to routinely assess the patient's clinical condition regarding shackles and document this assessment in the medical record. Such assessments ensure that patients' clinical condition with respect to shackling is both monitored and documented. In addition, the policy established recurring shackle assessments under which members of the health care team routinely assess incarcerated shackled patients for special circumstances, that is, clinical criteria health care teams can use to advocate for compassionate shackle removal or adjustment to less restrictive shackles. The special circumstances include but are not limited to the patient being terminally ill, critically ill, elderly, limited in mobility, or otherwise in a clinical condition wherein the care team agrees that shackles are unnecessary.

In the absence of legislation prohibiting shackling by law enforcement, this policy establishes a compassionate shackle removal process whereby providers can cite special circumstances to argue for shackle removal by law enforcement. While the BMC special circumstances emphasize provider autonomy, adding specific medical/clinical conditions to expand the circumstances will encourage health care staff to advocate for shackle removal for vulnerable patients, including those who are receiving treatments that affect their consciousness and/or mobility. The policy could go further by expanding the special circumstances to include patients who are unconscious (e.g., under general anesthesia), who are receiving regional anesthesia, who are receiving any form of anesthesia that affects consciousness, who are reliant on life-sustaining treatments or unable to ambulate, or who are pregnant, in labor, or under 12 weeks postpartum.

The BMC currently requires that law enforcement always maintain a clear line of sight with incarcerated patients. While law enforcement and correctional institutions are legally liable for any custody or safety issues that arise during health care, law enforcement presence can impact patient-provider relationships.[56] Law enforcement's presence during health care creates the opportunity for more dangerous encounters due to the introduction of weapons into the care facility.[57] Therefore, protections

for incarcerated patients would be further strengthened by adopting policies that do not require law enforcement to be in the same room as the patient. This will give providers flexibility in requesting that law enforcement step out of the room during sensitive conversations or procedures. Health care organizations could further support both patients and staff by training staff on how to effectively collaborate with law enforcement to promote patient dignity while simultaneously considering safety.

Legislative actions: New York City provided a clear guideline for the Department of Corrections, the Health Authority, and the Health and Hospitals Corporation regarding shackling of incarcerated patients seeking health care outside of secure medical wards of municipal hospitals.[58] The guideline discourages routine shackling of incarcerated patients, details medical circumstances in which incarcerated patients should never be shackled, and outlines data reporting recommendations. Key elements of this guideline can inform the evaluation of correctional agency internal policies at the federal, state, and local levels. The guideline can also inform development of federal, state, and local legislation to improve standards of care for incarcerated patients. Funding for research evaluating implementation of these policies is called for, given that no evaluation of the implementation of the New York City guideline was available as of August 2023.

The New York City guideline requires the Department of Corrections, the Health Authority and the Health and Hospitals Corporation to develop internal policies prohibiting routine shackling of incarcerated patients outside of secure medical wards of municipal hospitals. The guideline goes on to define shackling as “all devices which encircle the ankle or wrist of an inmate and restrict movement” and recommends that institutions establish clear procedures for shackling. The guideline also recommends that patients be shackled only at the direction of the chief correctional officer once he or she has reviewed evidence of custodial and safety risks posed by the patient.

The guideline promotes limited protections for incarcerated patients by defining medical circumstances in which patients should not be shackled. The guideline concedes that patients who behave violently and/or attempt escape may be shackled regardless of their medical condition. However, the guideline attempts to dissuade correctional staff from shackling patients out of convenience by suggesting that the decision to shackle a patient be routinely reevaluated by the chief correctional officer.

The guideline promotes patient advocacy among health care staff by recommending evaluating whether the shackles threaten the patient’s life, in which case they can advocate for immediate shackle removal.

The guideline further recommends that health care staff routinely assess and communicate whether shackling is medically contraindicated and should be removed.
The guideline promotes increased data collection by recommending that health care organizations keep written records summarizing the reason for shackling, details of the shackling, and patient information. The guideline also advocates for the creation of data reporting processes between health care and correctional institutions by recommending that health care staff routinely assess the patient's clinical condition regarding shackles and convey findings to the Department of Corrections.

The New York City guideline would be strengthened by broadening its definition of shackling, expanding the medical circumstances in which patients should not be shackled, extending the reach of its recommendations to include all health care settings, and fostering self-advocacy.

Adopting a more general definition of shackling, such as "physical, medical, or mechanical methods to restrict a patient's body or movements, for reasons that are not clinically necessary," would increase protections for incarcerated patients as shackling technologies change over time. The guideline recommends that patients not be shackled if they are "pregnant and admitted for delivery of a baby; or dependent on a ventilator or respirator; or in imminent danger or expectation of death."[58] Expanding the circumstances in which patients should not be shackled to include the special circumstances listed in the health care organizations section of this policy statement would extend protections to particularly vulnerable patients, including those who are elderly, postpartum, critically ill, and not ambulatory. The guideline would be further strengthened by prohibiting routine shackling of incarcerated patients in every setting, including in secure medical wards of municipal hospitals and in transport. Finally, the guideline does not promote patient autonomy because it does not recommend any policies for patients to report shackling. The guideline would therefore be strengthened by recommending that correctional institutions create accessible processes through which patients can report shackling and establish a clear process for investigating and rectifying patient grievances.

Recognizing that agencies do not always comply with the guidelines set by legislative bodies, compliance could be facilitated if the legislation included incentives such as funding consequences.

Potential impact of these evidence-based practices: Incremental progress toward ending shackling of incarcerated patients will reduce risks of negative health outcomes while increasing trust in health systems. Defining special circumstances in which shackles are prohibited and developing procedures for compassionate removal would improve health outcomes and mitigate health inequities brought on by

incarceration. Such policies would decrease the risk of physical harms associated with compression by handcuffs and other restraints such as skin breakdown, neurological damage, and fracture. Since providers are unlikely to remove shackles[37] and are often prohibited from doing so by corrections officers, expanding the circumstances in which shackles are prohibited would support quality care by restoring the patient-provider relationship.[27] Compassionate shackle removal would also allow for more thorough examination and faster emergency response.

Anti-shackling policies will have lasting economic benefits. Health spending could be reduced by ending shackling, as it results in avoidable health care costs from delayed emergency operations, falls, deliriums, venous thromboses, and even in-hospital deaths.[6,14] In any given year, half a million people are released from U.S. jails and prisons.[20,59] Experiences endured during incarceration have lasting impacts on people's health and health care choices after being released. Anti-shackling policies will decrease health care costs by reducing risk of mistrust of health systems, thereby increasing engagement in preventive care, lowering unnecessary emergency department visits, and increasing treatment adherence.[60,61]

In addition, when incarcerated patients are harmed by shackling, litigation can result in costly cases against health care providers and settlements. Health care policies that prioritize patient dignity, regardless of criminal legal status, can help health care workers and institutions avoid the costs associated with these lawsuits.

Provider burnout is often a result of incongruence between the values of the provider and the values of the system, including values around autonomy, competence, and interpersonal relationships.[62] Shackling can exacerbate that incongruence, leading to increased burnout and turnover. Each year, $4.6 billion is attributable to physician burnout in the United States; costs include physician turnover and reduced clinical hours.[63] For large health care organizations, this can represent as much as $7,600 per employed physician in lost productivity each year.[63] Anti-shackling policies can reduce health care system costs by providing health care workers with tools for advocating effectively for their patients, thereby reducing provider burnout, lost productivity, and turnover.

Opposing Arguments/Evidence

"Not shackling people increases the risk of violence against medical staff": The issue of violence against health care workers is a legitimate concern.[64] Preliminary survey data suggest that violence against medical staff, such as nurses, escalated during the increased tension wrought by the COVID-19

pandemic.[65] However, there is currently no evidence suggesting that incarcerated people are contributors to these trends. In fact, studies investigating the contributing factors to violence against medical staff reveal that hospital overcrowding, long waiting hours, staff shortages, and lack of staff training are key predictors of increased violence[66] and that these factors point to a variety of strategies for addressing the issue. The argument that incarcerated people are more violent in health care settings and therefore should be shackled is misguided and not based on existing evidence.

There is a prevalent myth that "violent" crimes involve physical harm. However, robbery (without assault) and drug-related offenses (such as stealing drugs and manufacturing methamphetamines) are considered violent crimes in many states.[11] Therefore, it is misguided to assume that people pose a safety risk because they were convicted of a violent crime. Shackling to prevent violence in the health care setting results in unnecessary suffering of patients who often pose no risk of violence. For instance, there have been reports of incarcerated patients being shackled while sedated and paralyzed.[1] There is also documentation of elderly incarcerated patients being shackled while dying, affecting dignity at the end of life.[27] While we agree that safety is important, this policy argues that existing shackling practices are not evidence based and need to be thoughtfully reconsidered.

Lastly, in and of itself, shackling is an act of violence with a long history of being used as a means of punishment, control, and oppression, especially against Black women, dating back to slavery.[31,67] Using violence to "prevent violence" is contradictory and does not address the root of important safety concerns for medical staff. Instead, health care settings should use evidence-based strategies that cause the least harm for all while ensuring medical staff safety. While real and perceived risks to staff safety from combative patients could contribute to staff burnout, comprehensive workplace violence prevention plans can mitigate staff concerns and ensure a safe work environment while also supporting the physical and emotional health of patients.

"Shackling protects against flight risk": Primary concerns about anti-shackling policies center around the preconception that an incarcerated patient may flee if deshackled. However, this assumption fails to account for the fact that patients who are critically ill or under anesthesia are unable to flee. In several legal challenges against perinatal shackling instances, the court concluded that prepartum, peripartum, and postpartum patients were not in a medical state to flee. For example, in the 1993 class action suit Women Prisoners of District of Columbia Department of Corrections v. District of Columbia, the court concluded that "the physical limitations of a woman in the third trimester of pregnancy…make complete shackling redundant and unacceptable in light of the risk of injury to a woman and baby.… While a

woman is in labor and shortly thereafter, however, the Court holds that shackling is inhumane."[68] This case outlines the inhumanity in shackling patients whose medical status bars them from posing such risk. In 2004, the court in Nelson v. Correctional Medical Services stated that "an inmate in the final stages of labor cannot be shackled absent clear evidence that she is a security or flight risk."[69] Yet again, this case references how patients' medical state dictates their inability to physically pose flight risk. These same principles can be extended to nonpregnant incarcerated patients. Patients who are critically ill or sedated are physically unable to pose a security risk; thus, shackling is deemed not only inhumane but also wholly unnecessary.[70] Creating clear guidelines against shackling vulnerable patients will provide the infrastructure necessary to ensure that those patients' constitutional rights are upheld. Furthermore, the data show that escapes are few and far between in general[6] but that if they are going to occur, it is most likely at the end of transportation back to the carceral facility after medical care has been received.[71]

"Shackling facilitates the work of health care providers": Shackling patients during procedures presents an increased risk for harm relative to performing the same procedures without shackles. Shackling is a physical and psychological barrier to clinicians providing the highest-quality medical care. There is evidence of incarcerated patients being shackled while undergoing physical examinations, outpatient office procedures, inpatient bedside procedures involving local or regional anesthesia and/or minimal to moderate sedation, and surgeries involving moderate to deep sedation or general anesthesia.[72]

Shackles manifest as a physical barrier in two ways. First, physical examinations and procedures are most effective and efficient with as few externally imposed movement restrictions as possible. Shackles impede exam maneuvers, preventing full range-of-motion and other assessments that require the patient to move or turn over, and complicate positioning for procedures in clinics, hospital rooms, and operating rooms.[73] Physician in training Neil Singh Bedi, founder and codirector of the Stop Shackling Patients Coalition, recites a time when he cared for a terminally ill 70-year-old female patient who was shackled to the bed. Bedi's patient remained shackled during medical examinations and treatment despite being too weak to lift her leg against gravity. Her shackles made it more difficult for health care providers to conduct comprehensive neurological exams and to roll the patient to prevent bed ulcers. Second, shackling increases risk of medical complications. Shackling sedated or anesthetized patients, for example, predisposes them to perioperative falls, tissue injury, and venous thromboembolism (VTE). Patients who are sedated or anesthetized cannot maintain balance or request removal of shackles that compress their tissue. As individuals recover from sedation or anesthesia, their immobility is already a risk factor for VTE, and being shackled exacerbates this risk.

Health care workers deserve physically and psychologically safe work environments. They also deserve adequate resources to perform their jobs, including adequate staff and reduced burdens of care when possible. As described in previous sections, shackling patients actually increases the burden of care on clinicians and impedes the therapeutic relationship between patients and clinicians.[6]

"The numbers of shackled individuals are small": Some proponents of shackling may argue that shackling bans are unnecessary because so few people are negatively impacted by shackling. Because shackling of incarcerated patients is not documented, there is no way of knowing the extent of the practice. However, prevalent indiscriminate shackling policies place 5.5 million people at risk of shackling and its negative impacts.[11] Regardless of the size of the population affected, health care policies should prioritize the health and dignity of all patients as an injury to one is an injury to all.

"Incarcerated individuals did something wrong and have sacrificed their rights as a result": According to the Eighth Amendment of the U.S. Constitution, incarcerated people should be free from cruel and unusual punishment regardless of the crime for which they are convicted.[74] As shown in the problem statement, shackling incarcerated patients violates this amendment. Therefore, shackling patients solely because of their criminal legal status is unconstitutional. In addition, the United Nations Committee Against Torture and the Universal Declaration of Human Rights affirm the basic rights of all people, regardless of criminal legal status. As demonstrated, shackling incarcerated patients is a human rights violation because it constitutes cruel and unusual punishment. The United States has already been criticized by the United Nations Committee Against Torture for this practice.[8] Such injustices call for further policy.

"Anti-shackling is already happening for those it would harm the most—perinatal people—so why bother with a broader statement?" A North Carolina resident was robbed and shot in March of 2022. The victim was not convicted of a crime, yet police officers arrested him on-site because of an outstanding warrant. They transported him to the hospital where he was handcuffed to his bed. Although the North Carolina legislature had passed a bill restricting shackling of incarcerated pregnant patients, the hospital had no process for deshackling nonpregnant patients.[52] Kristie Puckett, cofounder of abolitionist organization KEP2 and close friend of the patient, had to petition law enforcement and hospital staff to remove the shackles. The patient's handcuffs were finally removed 4 days after he had been admitted to the intensive care unit.

While 40 states have instituted laws restricting or banning shackles during the perinatal period to prevent intergenerational trauma and negative health effects on the family unit and community, it is not enough.[52,73] Exclusively focusing on perinatal people is unethical because shackling threatens the dignity and access to quality health care of other incarcerated people as well.[75] To improve population health, we cannot limit our sights to the perinatal period.

"If shackling is so bad, why doesn't this address all restraints?" The use of restraints by medical staff is an important topic: restraints also threaten the dignity, comfort, and well-being of those seeking medical care. However, this topic is outside the scope of the present policy statement. This statement focuses exclusively on shackling, defined as restraints used by law enforcement on incarcerated patients. As for restraints used by medical professionals, guidance on this topic is already provided by the CMS.

Action Steps

In order to promote the health and dignity of incarcerated people seeking health care, APHA calls on state and federal legislatures to pass laws requiring health care organizations and correction agencies to implement policies that ban shackling of patients receiving health care and requests that the CMS and general assemblies enforce those regulations.

In the absence of shackling bans, APHA calls on:

- Every individual health care system to implement policies that eliminate or reduce shackling of patients while receiving health care, such as (1) procedures for shackle removal and/or replacement of shackles with less restrictive restraints, (2) procedures assessing the physical health of patients shackled by law enforcement, (3) clear opportunities for reporting noncompliance with anti-shackling policies, (4) workplace violence prevention plans that incorporate anti-shackling of incarcerated patients, and (5) educational programming for health care providers to disseminate information on their rights to advocate for their patients.
- Federal, state, tribal, territorial, and local governments to pass legislation requiring the U.S. Marshals Service, Federal Bureau of Prisons, U.S. Immigrations and Customs Enforcement, state correctional agencies, and local jails to (1) ensure that incarcerated people are never shackled while receiving health care and are restrained only if there is an imminent safety risk, (2) ensure that incarcerated patients are never shackled if they meet the special circumstances listed in the evidence-based strategies section of this policy statement, (3) create clear reporting requirements for any correctional officer who shackles a patient, and (4) develop and disseminate a process that

allows incarcerated individuals to file complaints about violations of their rights to health care access.

- Congress to expediently pass legislation requiring the Occupational Safety and Health Administration to promulgate protective workplace violence prevention standards to protect health care and social service workers and include processes for recurring shackle assessments and compassionate shackle removal in those standards.
- The Centers for Disease Control and Prevention and the National Institutes of Health, in collaboration with community organizations, to (1) fund research on clinical practices for all incarcerated people, extending beyond the current research focused on pregnant and postpartum people; (2) fund research evaluating the implementation and effectiveness of anti-shackling policies in health care; and (3) develop a surveillance reporting program documenting use of shackling with incarcerated patients—disaggregated by race, income, immigration status, and other characteristics—using data provided by health care organizations and correctional institutions.

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