Human Rights in Hospitals: An End to Routine Shackling

Neil Singh Bedi[1], Nisha Mathur[1], Judy D. Wang[1], Avital Rech[1], Nancy Gaden[1], George J. Annas[1], and Sondra S. Crosby[1]

[1]Affiliation not available

December 28, 2023

Abstract

Medical students (NSB, NM, JDW), spearheaded revision of the written policy and clinical practice for shackling incarcerated patients at Boston Medical Center, the largest safety net hospital in New England. Across hospitals in the United States, routine shackling of incarcerated patients with metal handcuffs is widespread, except for pregnant prisoners, regardless of consciousness, immobility, illness severity, or age. The modified policy includes individualized assessment and allows incarcerated patients to be unshackled if they meet defined criteria. The students also formed the Stop Shackling Patients Coalition (SSP Coalition) of clinicians, public health practitioners, human rights advocates, and community members who share the goal of humanizing the inpatient treatment of incarcerated patients.

Introduction

Routine shackling of incarcerated patients with metal handcuffs is widespread in hospitals across the United States (US), with the exception of pregnant prisoners. Despite harmful effects on patients and national attention to health equity, incarcerated patients are routinely shackled regardless of consciousness, immobility, illness severity, or age.[1,2] A large cohort study (n = 1078) of Israeli hospitals found that 84% of incarcerated patients who have severely impaired mobility for medical reasons are shackled, nonetheless.[3] The discriminatory and dehumanizing practice of routinely applying shackles to incarcerated patients exacerbates existing care disparities by violating both medical ethics and human rights principles. The 2018 federal First Step Act prohibited "the shackling of pregnant prisoners in federal custody, except in certain cases."[4] As the name of this criminal justice bill suggests, the ban did not entirely eliminate shackling and the practice continues to impact nonpregnant incarcerated patients.[5]

There is a common misconception amongst healthcare professionals that they cannot influence the use of shackles to restrain their patients. By not challenging this practice within our healthcare institutions, the correctional system essentially governs aspects of patient care. Protocols for shackling incarcerated patients can and must be changed to respect human dignity and health, while simultaneously providing safety in the workplace.[6-9]

Harms to Individuals

Shackling impacts physical health in several ways. In the hospital setting, restraints can result in skin breakdown, circulation compromise, compressive neuropathies, fractures, increased fall risk, increased risk of delirium, and predisposition to severe vascular injury.[6,8,10,11] Clinicians may be limited in their ability to perform a thorough physical examination.[8]

Clinician bias against the shackled patient may also harm the clinician-patient relationship. In fact, the presence of shackles negatively affects empathy, precipitates diagnostic skepticism and elicits unsubstantiated fears of personal harm by the patient.[6] Shackles have led to insensitive, inappropriate, neglectful, or abusive actions by staff or associated authority figures, which in turn evokes a response of fear in patients along with

a loss of trust in the care team.[12] These negative healthcare interactions further stress incarcerated patients' post-carceral challenges within the healthcare system.[13]

Human Rights Violations

Routine shackling of incarcerated patients violates foundational international human rights principles, including those contained in the Universal Declaration of Human Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, and the International Covenant on Civil and Political Rights.[14-16] These principles are designed to protect human dignity and protect persons from discrimination and cruel, inhuman, and degrading treatment. Shackling patients who are critically ill or at the end of life is an affront to their human dignity, and increases pain and suffering in this vulnerable time. Routine shackling violates the United Nations (UN) Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules) – the internationally accepted standard for the treatment of prisoners.[17] Rule 48 addresses the use of restraints. See Box 1.

Box 1: UN Standard Minimum Rules (The Nelson Mandela Rules) Rule 48

1. When the imposition of instruments of restraint is authorized in accordance with paragraph 2 of rule 47, the following principles shall apply: (a) Instruments of restraint are to be imposed only when no lesser form of control would be effective to address the risks posed by unrestricted movement; (b) (c) The method of restraint shall be the least intrusive method that is necessary and reasonably available to control the prisoner's movement, based on the level and nature of the risks posed; Instruments of restraint shall be imposed only for the time period required, and they are to be removed as soon as possible after the risks posed by unrestricted movement are no longer present.
2. Instruments of restraint shall never be used on women during labor, during childbirth and immediately after childbirth.

In accordance with these Mandela Rules and the Charter of Fundamental Rights of the European Union, the head of the British prison service proclaimed that the "shackling of patients in hospital[s] should not occur," emphasizing that "security is important, but it should never blind us to the overriding need for compassion and humanity."[18, 19] In the Netherlands, chains are never used and handcuffs are used only in exceptional circumstances.[20] Our work amended shackling practices to introduce a risk-stratified, individualized protocol for American hospitals that aligns with human rights principles better upheld by Western nations. [21, 22]

From Changing Hospital Policy to Launching a National Movement

We began by writing and circulating a petition to local hospital affiliates and community members to raise awareness and support.[23] The petition then spread nationally, amassing 780 signatures across 129 institutions. The response demonstrated a consensus for change that enabled us to engage the hospital's executive leadership in policy reform. Next, we solicited input from key hospital stakeholders including public safety and patient-facing staff such as nurses, as well as medical, nursing leadership, and legal hospital leadership. Identifying shared values for patient care helped generate feedback to balance concerns for safety and liability with human dignity. We then engaged with hospital administration and proposed a modification to existing hospital policy. Following multiple meetings with and input from key stakeholders, the policy on shackling incarcerated patients was officially modified in February 2023. The core of the modified policy is a process that allows for the removal or modification of shackling in certain incarcerated patients and provides hospital personnel with a detailed protocol for the assessment and implementation of this policy. The policy outlines a schema for communication and decision-making among carceral facilities, hospital security, and the patient's healthcare team with the goal of providing dignified and humane care to incarcerated patients while maintaining hospital security.

The discourse around shackling practices reached beyond the walls of our hospital, inciting a national discus-

sion not only regarding the issue of shackling patients but how this practice could be brought to an end. In parallel to the conversations we were leading and progress we were making within Boston Medical Center, we also launched the Stop Shackling Patients Coalition (SSP) – a body of clinicians, public health practitioners, human rights advocates, and community members who share the goal of humanizing the inpatient treatment of incarcerated patients. SSP has now grown into a diverse task force and learning collaborative that meets to empower healthcare institutions from across the United States to change their shackling policies.

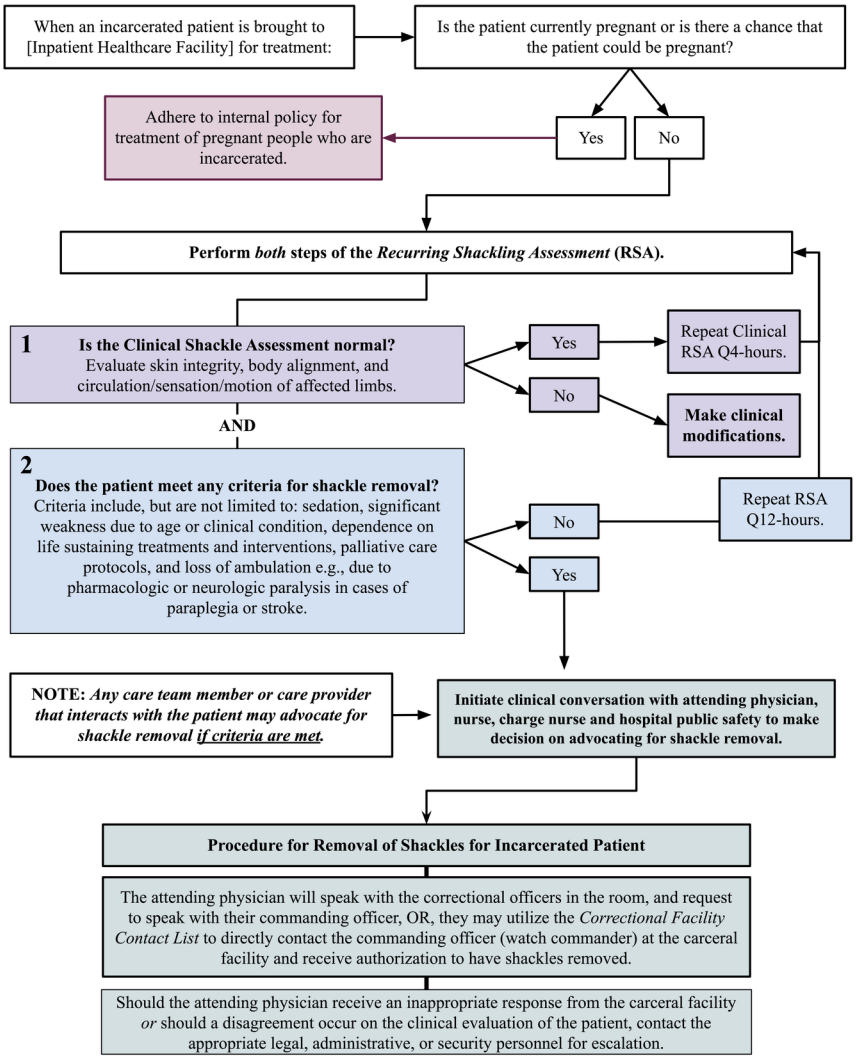

Figure 1: **Generalizable Protocol to Supplement Existing Hospital Policies for the Care of Incarcerated Patients** This flowchart depicts the generalizable model that can be followed by any healthcare institution for the removal of shackles or other unnecessary pre-hospital restraints applied to incarcerated patients.

A Novel Protocol

Though this protocol was designed and first implemented at Boston Medical Center, the goal is to disseminate

this policy across U.S. hospitals. For that reason, a generalizable protocol for shackle removal was designed that could be incorporated into existing hospital policies for the care of patients who are incarcerated. (Figure 1) The protocol parallels existing clinical assessments of any patient who is restrained in the hospital for medical or behavioral reasons and will be incorporated into the electronic health record (EHR). The EHR will identify incarcerated patients, prompt confirmation that the patient is not pregnant, and direct a member of the healthcare team to perform a Recurring Shackle Assessment (RSA) at regular intervals. The RSA functions to determine if a shackled, incarcerated patient meets any Special Circumstances for shackle removal (Figure 1). These include but are not limited to, the patient being sedated, significantly weakened due to age or clinical condition, dependent on life-sustaining treatments or interventions, placed on palliative care protocols, or having lost ambulation due to pharmacologic or neurologic paralysis such as in cases of paraplegia or stroke. If the patient meets any Special Circumstance, the protocol prompts the healthcare team to determine whether shackle removal is appropriate.

If appropriate, care team members notify hospital public safety leadership. The attending physician will then either (a) speak with the correctional officers who are accompanying the patient to contact their supervisor, or (b) contact the supervising correctional officer directly by utilizing the *Correctional Facility Contact List* (CFCL). The CFCL is an appendix to the hospital policy and includes direct points of contact for the care team at each local carceral facility. The supervising correctional officer may then order that the shackles be removed by the correctional officers who accompany the incarcerated patient. If there is a disagreement between the care team and the carceral facility about shackle removal, the care team will follow an appeal process, escalating the request to hospital public safety leadership and administration.

This protocol provides a process of regular assessment, systematically identifies incarcerated patients who may be safely unshackled, and provides a framework for restraint modification or removal. It also ensures that the safety of the healthcare team is protected. This protocol can be integrated into existing policy systems, EHR flowsheets, and healthcare workflows, while also providing individualized care for incarcerated patients. See Box 2.

Box 2: Excerpt from the updated policy on the *Care of Incarcerated Patients* – Boston Medical Center. In

Both policy and practice have begun to change. On May 13, 2023, the Massachusetts Medical Society resolved to condemn universal shackling, as well as advocate for individualized assessments for the removal of shackles and the use of the least restrictive alternative; the resolution was authored by SSP leadership.[24] Additionally in May 2023, a patient who was incarcerated, sedated, and intubated in Boston Medical Center was unshackled by correctional officers after the care team adhered to the new policy. Next steps include developing a plan in collaboration with the hospital to provide ongoing staff education about the modified policy. This is important because the protocol is driven by the ability of physicians, nurses, and other patient-facing staff to assess and recognize patients in Special Circumstances. EHR flowsheets will be developed by the hospital information technology team. Ongoing and iterative improvement will be important for sustainable implementation.

We encountered obstacles in parsing through patient and physician rights, engrained clinical practices, stigma, and culpability. Determining who can request the modification or removal of shackles, and who wields the practical authority to approve or deny such requests was complex. This stems from limited interactions, often through third-party health care or security contractors, between the carceral system and hospital-based medical care. Clearing the haze required us to identify written policies wherever possible and collaborate with colleagues from across clinical specialties, hospital administration, public safety, and legal services. SSP overcame barriers to change in a stepwise process that can serve as a model for other initiatives at the intersection of human rights and medicine.

The harmful and discriminatory routine shackling of incarcerated patients brazenly continues to occur across the American healthcare system. It is our hope that this model will be adopted by other healthcare institutions nationally to provide for regular assessment and advocacy of all incarcerated patients, ending universal

shackling practices. As healthcare professionals, we are obligated to scrutinize entrenched practices that perpetuate harm, and we must humanize the care of incarcerated patients.

References

1. Robinson M, Lavere K, Porsa E. End the Routine Shackling of Incarcerated Inpatients. J Hosp Med. 2021;16(6):376-377. doi:10.12788/jhm.3581
2. Lescure T. No Patient Should Have to Die in Shackles. The Washington Post | Opinion. https://www.washingtonpost.com/opinions/2021/10/05/no-patient-should-have-die-shackles/. Published October 5, 2021. Accessed October 12, 2021.
3. Bar N, Naaman E, Rosin D, et al. Shackling incarcerated people in Israeli hospitals—a multicentre study followed by a national intervention programme. The Lancet. 2023;402(10398):285-287. doi:10.1016/s0140-6736(23)01242-4
4. First Step Act of 2018, United States Congress, Public Law 115–391 S.756, 115th Congress
5. Richardson A. Shackling of pregnant prisoners is ongoing. Bill of Health. https://blog.petrieflom.law.harvard.edu/2020/03/04/shackling-of-pregnant-prisoners-is-ongoing/#:~:text=In%202018%2C%20the%20First%20Step,prevent%20serious%20harm%20or%20escape. Published March 3, 2020. Accessed March 23, 2023.
6. Haber LA, Pratt LA, Erickson HP, Williams BA. Shackling in the Hospital. J Gen Intern Med. 2022;37(5):1258-1260. doi:10.1007/s11606-021-07222-5
7. Grundy SJ, Peterson M, Brinkley-Rubinstein L. Comprehensive Reform Urgently Needed in Hospital Shackling Policy for Incarcerated Patients in the United States. J Correct Health Care. 2022;28(6):384-390. doi:10.1089/jchc.21.07.0070
8. Robinson M, Lavere K, Porsa E. End the Routine Shackling of Incarcerated Inpatients. J Hosp Med. 2021;16(6):376-377. doi:10.12788/jhm.3581
9. House KT, Kelley S, Sontag DN, King LP. Ending Restraint of Incarcerated Individuals Giving Birth. AMA J Ethics. 2021;23(4):E364-E368. Published 2021 Apr 1. doi:10.1001/amajethics.2021.364
10. Haddad FS, Goddard NJ, Kanvinde RN, Burke F. Complaints of pain after use of handcuffs should not be dismissed. BMJ. 1999;318(7175):55. doi:10.1136/bmj.318.7175.55
11. National Task Force on the Use of Restraints with Pregnant Women under Correctional Custody. Best Practices in the Use of Restraints with Pregnant Women Under Correctional Custody. U.S. Department of Health and Human Services, 2012. Department of Justice Grant No. 2010-DJ-BX-K080.
12. Scarlet S, Dreesen E. Surgery in Shackles: What Are Surgeons' Obligations to Incarcerated Patients in the Operating Room?. AMA J Ethics. 2017;19(9):939-946. Published 2017 Sep 1. doi:10.1001/journalofethics.2017.19.9.pfor1-1709
13. Frank JW, Wang EA, Nunez-Smith M, Lee H, Comfort M. Discrimination based on criminal record and healthcare utilization among men recently released from prison: a descriptive study. Health Justice. 2014;2:6. doi:10.1186/2194-7899-2-6
14. United Nations. UN General Assembly Resolution 217A: Universal Declaration of Human Rights. 10 December 1948.
15. United Nations. UN General Assembly Resolution 2106: International Convention on the Elimination of All Forms of Racial Discrimination. 21 December 1965
16. United Nations. UN General Assembly Resolution 2200A: International Covenant on Civil and Political Rights. 16 December 1966
17. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). As adopted by the 70th Session of the UN General Assembly. 08 January 2016.
18. European Union. Charter Of Fundamental Rights Of The European Union. 07 December 2000. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:12012P/TXT&from=SL
19. Westall J. Shackling of prisoners denounced. BMJ. 1997;314(7078):393. doi:10.1136/bmj.314.7078.393a
20. Dillner L. Shackling prisoners in hospital. BMJ. 1996;312(7025):200. doi:10.1136/bmj.312.7025.200

21. Ombudsman South Australia. Ombudsman investigation into the Department for Correctional Services in relation to the restraining and shackling of prisoners in hospitals. July, 2012. https://www.ombudsman.sa.gov.au/publication- documents/investigation-reports/2012/ correctional_services_july_-2012.pdf (accessed June 20, 2023).
22. HM Prison and Probation Service. Prevention of escape: external escorts policy framework. Ministry of Justice and HM Prison and Probation Service, UK. 2023. https://assets. publishing.service.gov.uk/government/ uploads/system/uploads/attachment_data/ file/1143131/prevention-escape-external- escorts.pdf (accessed June 20, 2023).
23. Bedi NS, Mathur N, Wang JD. Stop Shackling Patients: A Petition to Humanize the Care of Incarcerated Patients at Boston Medical Center. Humanities Commons. Accessed July 21, 2023. https://doi.org/10.17613/3sc0-ne02.
24. Massachusetts Medical Society Resolution A-22 A106: Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals. Adopted May 2023.