UCSF
UC San Francisco Previously Published Works

Title
Shackling in the Hospital

Permalink
https://escholarship.org/uc/item/1519s54b

Journal
Journal of General Internal Medicine, 37(5)

ISSN
0884-8734

Authors
Haber, Lawrence A
Pratt, Lisa A
Erickson, Hans P
et al.

Publication Date
2022-04-01

DOI
10.1007/s11606-021-07222-5

Peer reviewed

eScholarship.org Powered by the California Digital Library
University of California

Shackling in the Hospital

Lawrence A. Haber, MD[1]*, Lisa A. Pratt, MD, MPH*[2]*, Hans P. Erickson, JD*[3]*, and Brie A. Williams, MD, MS*[4]

[1]Division of Hospital Medicine, Department of Medicine, Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center, University of California, 1001 Potrero Ave, Building 5, San Francisco, CA, USA; [2]Department of Public Health, Jail Health Services, San Francisco, CA, USA; [3]Office of the Federal Public Defender, Albuquerque, NM, USA; [4] Department of Medicine, Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center, The Center for Vulnerable Populations, University of California, San Francisco, CA, USA.

Hospitalized incarcerated patients are commonly shackled throughout their duration of treatment in community medical centers to prevent escape or harm to others. In the absence of overarching policies guiding the shackling of non-pregnant, incarcerated patients, clinicians rarely unshackle patients during routine care. We provide a medical-legal lens through which to examine inpatient shackling, review the limited evidence supporting the practice, and highlight harms associated with shackling in the hospital. We conclude by offering guidance to advance evidence-based shackling practices that prevent physical harm, reduce prejudice towards incarcerated patients, and relinquish reliance on shackles in favor of tailored security measures.

J Gen Intern Med 37(5):1258–60
DOI: 10.1007/s11606-021-07222-5
© Society of General Internal Medicine 2021

INTRODUCTION

Incarceration is associated with adverse health outcomes, including a 2-year decline in life expectancy for each year served in prison.[1] This is particularly notable as Black, Indigenous, and people of color are disproportionately overrepresented among the 2.1 million incarcerated people in US jails and prisons.[2] When an incarcerated patient requires medical care that exceeds the capacity of the correctional facility in which they are housed, they are transferred to a community hospital. Inequitable experiences in community hospitals may further contribute to health disparities.[3]

Patients in the custody of law enforcement are commonly shackled with metal chains and cuffs throughout the duration of their treatment in community medical centers. Although Centers for Medicare and Medicaid Services standards mandate the least restrictive form of medical restraint for agitated or combative patients, no such national policy or common code of ethics applies to shackling in the hospital.[4] While federal and individual state laws regulate shackling of pregnant women,[5] no similar protections guide shackling of non-pregnant, incarcerated patients in the acute care setting. As a result, healthcare professionals rarely unshackle patients during routine hospital care.[6]

We provide a medical-legal lens through which to examine the practice of inpatient shackling, review evidence supporting indiscriminate shackling, highlight medical harms associated with the practice, and offer guidance for healthcare professionals and institutions to advance evidence-based shackling practices for incarcerated patients.

LEGAL CONTEXT AND PATIENT RIGHTS

Security in most community medical facilities does not approximate correctional standards and few hospitals have dedicated medical forensic units. In this context, custody officers have broad discretion over the use of shackles for hospitalized patients when reasonably related to penological interests, such as preventing escape or harm to others.

Medical care of incarcerated patients is protected under the Eighth Amendment to the US Constitution, which prohibits "cruel and unusual punishment." Patients who are detained but who have not been convicted of a crime, such as those held pending trial or brought directly from the community to the hospital in custody, cannot be subjected to any form of punishment. People with preexisting disabilities have additional protections under the law.

Yet shackling can infringe on incarcerated patients' rights to the same standard of healthcare available in the community and, as the United Nation's Mandela Rules assert, to be treated with respect due to their inherent dignity as human beings.[7] Shackling, if disproportionate to penological goals or for prolonged periods inhibiting freedom of bodily movement, could be viewed as punishment prohibited under the Eighth Amendment.

The rights of incarcerated patients may be further infringed upon by clinicians who, due to conscious or unconscious bias, treat patients who are shackled differently from others. The criminal justice system recognizes that shackled individuals are prejudged. As a result, the right to due process restricts the use of physical restraints on criminal defendants during trial since shackles lead jurors to draw strongly negative inferences about a defendant's character.[8] In court and in most correctional circumstances, incarcerated individuals remain

Received June 1, 2021
Accepted October 15, 2021
Published online January 28, 2022

unshackled unless law enforcement demonstrates credible needs related to safety.

DO SHACKLES SERVE THEIR INTENDED PURPOSE IN THE HOSPITAL?

Data on the incidence of escape of incarcerated patients while hospitalized in community medical facilities is limited. A single study from 2011 using online media tracking identified 99 discrete incidents of incarcerated patients escaping medical facilities or medical transport over the course of a year.[9] This represents a vast minority of all incarcerated individuals and a small fraction of those seen within healthcare settings.

Articles in the lay press describe hospitalization and medical transport as times of vulnerability for law enforcement.[10] Press reports detail scenarios where shackles were removed prior to escape as well as instances in which shackles were in place during escape.[11] Such reports do not demonstrate a relationship between indefinite shackling in healthcare settings and prevention of escape or harm to others.

Further research on the incidence of escape or harm to personnel by incarcerated patients is needed. Moving away from anecdotal reports towards systematic collection of data identifying patient, incident, and facility-level contributing variables [12] would allow better assessment of the injudicious use of shackles in the healthcare setting.

DO SHACKLES LEAD TO HARM FOR PATIENTS?

While little if any data exist on the benefit of shackles, considerable data exist about their harm. Shackles cause proactive injury to patients. Over-tightening of cuffs, potentially compounded by forced limb movement, has been shown to damage underlying structures leading to skin breakdown,[13] compressive neuropathies, and fractures of the small bones of the hand.[14]

Shackling also predisposes to passive harm. Chain restrictions can impede exam maneuvers, delay positioning during seizures, predispose to falls, promote deconditioning, and elevate risk of venous thrombosis.[5] Surgeons describe a reduced therapeutic alliance and heightened vulnerability shackles incur for patients when placed in the operating room.[15] For those admitted with terminal diagnoses, shackles limit palliative providers' ability to provide dignity-driven end of life care.[16]

When blanket shackling policies do not account for individual medical risk assessment, patients with disabilities are disproportionately impacted. A shackled patient with hemiplegia may lose the ability to perform independent activities if their functional deficits are not accounted for in limb placement. An inability to comply with continuous cuffed restraint can precipitate delirium in those with impaired cognition.

Finally, as they do with members of a jury, shackles exacerbate clinicians' biases. Qualitative studies of physicians and nurses reveal that shackles negatively affect empathy towards incarcerated patients, precipitate diagnostic skepticism, and elicit fears of personal harm. [6,17]

CONSIDERATIONS FOR CLINICIANS AND HEALTHCARE CENTERS TO ADVANCE CARE

Allowing hospitalized patients to remain indefinitely shackled during medical treatment can lead to harmful outcomes not clearly outweighed by a demonstrated safety benefit. Despite compassionate care from clinicians,[6] patients remain in shackles as a default practice. Table 1 addresses common misconceptions that perpetuate resistance to removal of shackles in the acute care setting.

As a form of harm reduction, clinicians should regularly examine cuff sites for injuries and assess inpatients for conditions particularly impacted by restraint. Shackles should be removed during encounters to preserve therapeutic relationships and obtain accurate examinations. Writing specific treatment orders pertaining to movement can prompt device removal outside of discrete clinical interactions.

Clinicians should familiarize themselves with state and facility policies, including contractual relationships. If clinicians encounter barriers to unshackling patients during treatment or apprehension addressing custody officers, one starting point is to contact the patient's healthcare provider at the referring correctional institution, who can offer context and

Table 1 Misconceptions Around Shackling of Hospitalized Incarcerated Patients

Misconception	Explanation
Shackles do not cause harm to patients	Shackling can cause active and passive harm to hospitalized patients as well as affect healthcare provider empathy
Most providers unshackle patients during exams	Studies of physicians and nurses demonstrate that the minority of providers remove shackles during encounters
Providers may not ask for removal of shackles	Providers can request for shackles to be removed for a demonstrated medical necessity
If shackles are removed, security breaches become the responsibility of the provider	Providers are tasked with providing medically necessary and ordered care without bias to incarcerated status. Security remains the responsibility of the custody officer
Shackles keep providers safe from violent offenders	The minority of those in custody have committed or are accused of violent crimes. Removal of shackles does not equate to an absence of security
Shackling is part of a prisoner's punishment	Not all patients in custody have been tried. Once tried and sentenced, restriction of freedom is the primary punishment. In correctional facilities and court, prisoners frequently interact with lawyers, administrators, guards, medical and non-medical staff without physical restraints of any kind

patient advocacy. Medical centers should standardize routes of communication between clinicians and custody officers to facilitate collaborative relationships that ensure medical and security needs are met. [18]

For hospitals, aligning policy on shackling of incarcerated patients with policy guiding restraint of non-incarcerated patients creates parity and promotes the least restrictive form of restraint needed to secure a patient. This change involves working from the supposition that all hospitalized patients should remain unchained until a proven need for such restriction arises. Such structural transformation mitigates the risks of active and passive harm to patients, lessens the prejudice shackles precipitate, and reflects shackling practices outside of healthcare settings.

Healthcare institutions should acknowledge the safety concerns of staff,[6] real or perceived, as a barrier to care. Targeted interventions that address such concerns without reliance on shackles include individualized security risk assessments on admission, strategic room allocation, protocols for supervised patient-provider interactions, and use of soft-restraints when necessary. Quality advocates should recognize shackling's potential for patient harm and establish systems to monitor their use.

Housing incarcerated individuals in dedicated medical forensic units has been proposed as a method to reduce reliance on prolonged shackling. [19] As the incarcerated population makes up a small minority of patients in community hospitals,[4] constructing and staffing dedicated units may not be feasible for most institutions. The creation of dedicated forensic units also creates a separate but equal premise where incarcerated patients receive care in a distinctly different setting than non-incarcerated hospitalized patients, which may come with unintended balance measures.

Healthcare professionals are taught to employ a risk–benefit analysis to any interventions affecting patient health. Yet, by deferring the management of shackles in the acute care setting, we passively accept a structure that perpetuates inequities in care for incarcerated individuals, a population already at risk for poor health outcomes. Providers should work collaboratively with custody officers to identify the least restrictive means available to secure a patient and correctional representatives should be tasked with proactively demonstrating a correctional necessity that requires a patient to be shackled. In this way, clinicians and institutions can deliver legally grounded care that prevents unnecessary physical harm, reduces prejudice towards incarcerated patients, and relinquishes an overreliance on shackles in favor of security measures tailored to the needs of patients, providers, and custody officers.

Acknowledgements: *Dr. Williams' time is covered, in part, by a grant from the National Institute on Aging (The Aging Research in Criminal Justice Health Network; Grant #R24 AG065175). The National Institute on Aging grant funding that supports a portion of Dr. William's time for research efforts.*

Corresponding Author: *Lawrence A. Haber, MD; Division of Hospital Medicine, Department of Medicine, Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center, University of California, 1001 Potrero Ave, Building 5, San Francisco, CA 6A1094110, USA (e-mail: lawrence.haber@ucsf.edu).*

Declarations:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

REFERENCES

1. **Patterson EJ.** The dose-response of time served in prison on mortality: New York State, 1989-2003. Am J Public Health. 2013;103(3):523-8. https://doi.org/10.2105/AJPH.2012.301148.
2. **Bailey ZD, Feldman JM, Bassett MT.** How Structural Racism Works - Racist Policies as a Root Cause of U.S. Racial Health Inequities. N Engle J Med. 2021;384(8):768-73. https://doi.org/10.1056/NEJMms2025396.
3. **Rorvig L, Williams B.** Providing Ethical and Humane Care to Hospitalized, Incarcerated Patients With COVID-19. Am J Hosp Palliat Care. 2021;38(6):731-33. https://doi.org/10.1177/1049909121994313.
4. **Haber LA, Erickson HP, Ranji SR, Ortiz GM, Pratt LA.** Acute Care for Patients Who Are Incarcerated: A Review. JAMA Intern Med. 2019;179(11):61–1567. https://doi.org/10.1001/jamainternmed.2019.3881.
5. **Ferszt GG, Palmer M, McGrane C.** Where Does Your State Stand on Shackling of Pregnant Incarcerated Women? Nurs Womens Health. 2018;22(1):17-23. https://doi.org/10.1016/j.nwh.2017.12.005.
6. **Brooks KC, Makam AN, Haber LA.** Caring for Hospitalized Incarcerated Patients: Physician and Nurse Experience. J Gen Intern Med. 2021:1–3. https://doi.org/10.1007/s11606-020-06510-w.
7. Basic Principles for the Treatment of Prisoners, United Nations General Assembly, 45/111, Dec. 14 1990.
8. **Justia.** Holbrook v. Flynn, 475 U.S. 560 (1986). https://supreme.justia.com/cases/federal/us/475/560/. Accessed May 28, 2021.
9. **Mikow-Porto VA, Smith TA.** The IHSSF 2011 Prisoner Escape Study. J Healthc Prot Manage. 2011;27(2):38-58.
10. **Kutner M.** Recent Prisoner Escapes Have One Common Factor: Hospital Visits. 2015. https://www.newsweek.com/recent-prisoner-escapes-have-one-common-factor-hospital-visits-319692. Accessed May 28, 2021.
11. **Powell BL.** Federal Officials Join Search for Ohio Rape Suspect Who Escaped. 2017. https://www.nbcwashington.com/news/national-international/prisoner-charged-with-rape-overpowers-deputy-steals-his-gun/2019538/. Accessed May 28, 2021.
12. **Peterson BE, Fera A, Mellow J.** Escapes From Correctional Custody: A New Examination of an Old Phenomenon. The Prison Journal. 2016;96(4):511-33. https://doi.org/10.1177/0032885516650873.
13. **Haber LA, O'Brien M.** Shackling Ulcer: an Upper Extremity Ulcer Secondary to Handcuffs. J Gen Intern Med. 2021 Feb 24. https://doi.org/10.1007/s11606-021-06654-3.
14. Haddad FS, Goddard NJ, Kanvinde RN, Burke F. Complaints of pain after use of handcuffs should not be dismissed. BMJ. 1999;318(7175):55. https://doi.org/10.1136/bmj.318.7175.55.
15. **Scarlet S, Dreesen E.** Surgery in Shackles: What Are Surgeons' Obligations to Incarcerated Patients in the Operating Room? AMA J Ethics. 2017;19(9):939-46. https://doi.org/10.1001/journalofethics.2017.19.9.pfor1-1709.
16. **DiTomas M, Bick J, Williams B.** Shackled at the End of Life: We Can Do Better. Am J Bioeth. 2019;19(7):61-3. https://doi.org/10.1080/15265161.2019.1618957.
17. **Zust BL, Busiahn L, Janisch K.** Nurses' experiences caring for incarcerated patients in a perinatal unit. Issues Ment Health Nurs. 2013;34(1):25-9. https://doi.org/10.3109/01612840.2012.715234.
18. **Gahler JR, et al.** Maryland's Model Guidelines for the Security of Prisoners for EMS and Hospital Settings. 2008. https://www.mhaonline.org/docs/default-source/Resources/ebola/security-of-prisoners-for-ems-and-hospital-settings-final.pdf?sfvrsn=2. Accessed May 28, 2021.
19. **Robinson M, Lavere K, Porsa E.** End the Routine Shackling of Incarcerated Inpatients. J Hosp Med. 2021. https://doi.org/10.12788/jhm.3581

Publisher's Note: *Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.*