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### VIEWPOINT: PEER-REVIEWED ARTICLE

#### Ending Restraint of Incarcerated Individuals Giving Birth

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##### Abstract

Advocates have long suggested making shackling incarcerated people during childbirth illegal. Yet exceptions would likely still allow prison personnel to implement restraint and leave clinicians no course for freeing a patient. This article argues that clinicians' assessments of laboring individuals' clinical needs must be prioritized, ethically and legally. This article also explains that, without strong policies in place, some clinicians will not feel empowered to demand that a patient be freed during labor. Beyond prohibiting restraint of laboring individuals, health care organizations must support clinicians seeking to execute their ethical duties to care well and justly for patients. Toward this end, this article proposes a model policy.

##### Why Is This Done, Why Stop?

Shackling incarcerated individuals giving birth in hospitals has 2 origins: protecting the public by preventing an escape and protecting health care worker safety. Jails and prisons are responsible for actions of individuals under their control and can be held liable for harm caused by those individuals if it is determined that jail or prison personnel acted negligently (ie, failing to secure them). During 2016-2017, 753 individuals in the United States gave birth in hospitals while incarcerated.<sup>1</sup> It is not known precisely how many **incarcerated individuals giving birth** were chemically or physically restrained during their hospitalizations, but restraint is common.<sup>2</sup> There are 3 clear reasons this practice should end: (1) physical demands of labor and delivery make escape attempts extremely unlikely, (2) no pregnant or laboring incarcerated individual has ever been documented as having escaped a hospital,<sup>3</sup> and (3) most women experiencing incarceration "are not violent offenders, so restraining them to prevent attacks on workers is largely unnecessary."<sup>4</sup>

We argue that clinicians must prioritize patients' best clinical and ethical interests and that organizations' policies must support clinicians trying to do so. Justice and nonmaleficence, other cornerstone values of health care professionalism, require that organizations prohibit restraint of individuals giving birth on their premises and that organizational policies be equitably administered. After discussing current policy and law on restraint of laboring individuals, we (1) propose a model policy for health care

organizations to adapt and (2) suggest that organizational leaders educate clinicians on relevant laws that recognize their authority to protect pregnant individuals experiencing incarceration.

### **Prioritizing Safety and Equity**

Manacled or fettered incarcerated individuals giving birth in hospitals is ethically unacceptable because it undermines safe, compassionate birth practice and because **people of color** are disproportionately more likely to be subjected to it.<sup>5</sup> Carolyn Sufrin, a medical anthropologist and obstetrician-gynecologist explains: “In labor, emergencies arise unexpectedly. We might need to do an emergency C-section if there are signs of distress or the baby’s shoulder could get stuck in the birth canal. When one of these emergencies arises, as a healthcare professional, we need to focus on our patient, not on asking a guard to unshackle her.”<sup>6</sup> The American Psychological Association supports protecting incarcerated individuals who are pregnant or giving birth, citing numerous states’ indiscriminate use of restraints.<sup>7</sup>

There can be cases in which restraint use is ethically and clinically appropriate, and there are some cases in which restraint can be a compassionate thing to do, but restraint as a blanket policy is harmful and unacceptable. In hospital settings, only clinicians should determine whether and when restraint is indicated for a specific patient at a specific time. Clinicians who work with individuals giving birth are practiced in assessing a patient’s need for restraint interventions and balancing such need against risks of harm to her and her child.<sup>8</sup> Clinicians are also trained to balance multiple ethical and clinical goals when managing a patient’s care and to respond to some agitated patients without using restraints.

### **Current Law**

Although some advocates have suggested outlawing shackling, laws written to ban shackling incarcerated people giving birth frequently contain exceptions that preserve prison personnel’s authority to restrain patients—even in hospital settings—despite clinicians’ requests to free a patient for safety, equity, or adherence to standard practice. Some laws seem to recognize that people who are pregnant and incarcerated pose small risk of escape or harm to others. Laws governing federal prisons<sup>9</sup> and laws governing prisons and jails in 20 states<sup>10</sup> specify that restraining pregnant individuals is prohibited and that prison personnel must defer to a clinical team. These laws do not ban use of restraints by prison personnel but recognize clinicians’ authority in protecting individuals in labor. Clinicians must be educated about these laws and what they say about their roles, authority, and duties, since clinicians who do not know they can **order restraint removal** likely will not do so.<sup>11</sup>

### **Equity and Movement**

Many individuals in labor often sway back and forth, stand, crouch, pace, and sit in a variety of positions in order to bear intense pain, so unnecessary restraint can be traumatizing.<sup>12</sup> We must interrogate unnecessary risk imposition and ask, *Who exactly is being harmed?* Black women are incarcerated at a rate that is almost 3 times higher than White women.<sup>5</sup> Accordingly, the practice of handcuffing pregnant patients will disproportionately traumatize (or retraumatize) Black people. The American Civil Liberties Union and the American College of Obstetricians and Gynecologists do not support routine shackling of pregnant individuals who are incarcerated<sup>2,3</sup> because it is dangerous, unduly restricts movement, and can increase life-threatening risk (ie, for blood clots).<sup>13</sup>

Further study on health risks of shackling during childbirth is needed. The US federal government does not require prisons or jails to collect data about pregnancy and birth among women experiencing incarceration,<sup>7,14</sup> and this should change, given the ease with which such data could be maintained.<sup>1</sup> But absence of data does not make it unreasonable to suppose that restraints could generate worse outcomes for individuals experiencing incarceration, since it is known that negative birth experiences can affect parent-newborn bonding.<sup>3</sup> We encourage legislation requiring data collection, especially about race.

### **Toward Just Organizational Policy**

Clinicians and organizations must ensure that birth is as safe and patient centered as possible for all patients. All patients deserve standard prenatal care, prenatal education, parenting classes, and other resources.<sup>16</sup> When a woman arrives at a hospital in active labor, the primary focus should be on ensuring her and her child's safety. Organizational policies should comply with applicable federal and state law, be concise and easily readable, use language that reinforces all patients' personhood and dignity, and limit exceptions in accordance with 3 features of model policy:

1. A pregnant patient in any stage of delivery may not be placed in restraints at any time.
2. A patient in postdelivery recuperation shall not be placed in restraints, except under extraordinary circumstances (ie, the patient presents immediate, serious threat to self or others or presents immediate, credible risk of escape that cannot be curtailed by other measures). If clinicians determine that restraints must be used, restraints shall be the least restrictive and most reasonable available.
3. Leg or waist restraints shall not be used on a pregnant or postpartum patient.

Clinicians have duties to assume active roles in ending shackling, which compromises safety and compassion, inconsistent with federal and many states' laws. Health care organizations must act to educate and support clinicians looking out for their patients' interests and seeking to provide equitable care.

### **References**

1. Sufrin C, Beal L, Clarke J, Jones R, Mosher WD. Pregnancy outcomes in US prisons, 2016-2017. *Am J Public Health*. 2019;109(5):799-805.
2. ACLU Reproductive Freedom Project; ACLU National Prison Project. ACLU briefing paper: the shackling of pregnant women and girls in US prisons, jails and youth detention centers. American Civil Liberties Union. Accessed February 25, 2021. <https://www.aclu.org/other/aclu-briefing-paper-shackling-pregnant-women-girls-us-prisons-jails-youth-detention-centers>
3. Committee on Health Care for Underserved Women. ACOG Committee Opinion No. 511: health care for pregnant and postpartum incarcerated women and adolescent females. American College of Obstetricians and Gynecologists. November 2011. Reaffirmed 2016. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/11/health-care-for-pregnant-and-postpartum-incarcerated-women-and-adolescent-females>

4. DeAngelis T. The restraint of pregnant inmates. *Monitor on Psychology*. 2016;47(6):26. Accessed February 25, 2021. <https://www.apa.org/monitor/2016/06/restraint-inmates>
5. Nellis A. The color of justice: racial and ethnic disparity in state prisons. Sentencing Project. June 14, 2016. <https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/>
6. Cohen RD, Chang A. Federal legislation seeks ban on shackling of pregnant inmates. *NPR*. December 5, 2018. Accessed February 25, 2021. <https://www.npr.org/sections/health-shots/2018/12/05/673757680/federal-legislation-seeks-ban-on-shackling-of-pregnant-inmates>
7. Public Interest Government Relations Office. End the use of restraints on incarcerated women and adolescents during pregnancy, labor, childbirth, and recovery. American Psychological Association. August 2017. Accessed August 7, 2020. <https://www.apa.org/advocacy/criminal-justice/shackling-incarcerated-women.pdf>
8. Sufrin C. Making mothers in jail: carceral reproduction of normative motherhood. *Reprod Biomed Soc Online*. 2018;7:55-65.
9. 18 USC §4322 (2021).
10. Richardson A. Shackling of pregnant prisoners is ongoing. *Bill of Health*. March 4, 2020. Accessed February 15, 2021. <https://blog.petrieflom.law.harvard.edu/2020/03/04/shackling-of-pregnant-prisoners-is-ongoing/>
11. Jeffers K, Siddiq H, Martinez-Hollingsworth A, et al. Nurses should oppose police violence and unjust policing in healthcare. *Int J Nurs Stud*. Published online August 1, 2020.
12. Sufrin C. Pregnancy and postpartum care in correctional settings. National Commission on Correctional Health Care. November 2014. Accessed February 25, 2021. <https://www.ncchc.org/filebin/Resources/Pregnancy-and-Postpartum-Care-2014.pdf>
13. Shackling pregnant inmates is still a practice in many states. *CBS News*. March 13, 2019. Accessed February 25, 2021. <https://www.cbsnews.com/news/shackling-pregnant-inmates-is-still-a-practice-in-many-states/>
14. Clarke JG, Simon RE. Shackling and separation: motherhood in prison. *Virtual Mentor*. 2013;15(9):779-785.
15. Daniel R. Prisons neglect pregnant women in their healthcare policies. Prison Policy Initiative. December 5, 2019. Accessed February 25, 2021. <https://www.prisonpolicy.org/blog/2019/12/05/pregnancy/>

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