

## Shackling incarcerated people in Israeli hospitals—a multicentre study followed by a national intervention programme

Thousands of incarcerated people (individuals who have been imprisoned or detained) are treated in Israeli medical centres each year. The custodial authority during their hospital stay is the local police, the Israel Prison Service (IPS), or the Israeli Army. Positioned at the crossroads of security and human rights, the treatment of these patients almost invariably raises major ethical issues. Shackling during hospital stay is associated with physical, mental, and social effects, which inevitably impair treatment.<sup>1</sup> International guidelines, such as the Mandela Rules,<sup>2</sup> determine that health-care standards should not differ for incarcerated people and, given that most incarcerated patients do not pose a direct threat,<sup>3</sup> unselective shackling is considered a disproportional measure. In this regard, Israeli law states that incarcerated patients should not be shackled, except in selected circumstances for which individual assessment is required (mainly if there is a direct threat of violence or escape).<sup>4</sup> Numerous manuscripts have conceptually addressed the ethical, legal, and medical considerations of shackling of incarcerated patients<sup>5-7</sup> but, to our knowledge, quantitative data on the extent and nature of shackling during hospital stays have never been published.

Under the joint auspices of the ethics board of the Israeli Medical Association and the ethics bureau of the Israeli Nurses Association, we undertook a national programme to document the proportion of shackling during the hospital stays of incarcerated individuals in 14 general hospitals that agreed to participate between Jan 1, 2020, and March 31, 2022, including five of the

seven tertiary hospitals in Israel. We excluded psychiatric hospitals because they face a unique risk of violence but also possess better expertise to address these risks than general hospitals. Data were collected prospectively at each of the institutions by a respective local investigator who was not involved in the care of patients and acted on behalf of the hospital management. In four hospitals, prospective assessment was not possible, but we managed to collect data retrospectively from administrative records. The retrospective data did not include some baseline data and details on the exact position of the shackles. Five hospitals included both inpatients and outpatients (including emergency room visits) while the other nine logged data on inpatients only. In all cases, documentation was systematically generated. The collected data and analyses were based on hospital visits and not individual patients. A patient might have thus been included more than once if they visited the hospital on separate occasions. With these data, we aimed to trigger public discussion and, subsequently, national reforms. This surveillance programme has been approved by the ethics committee of Shaare Zedek Medical Center (The Hebrew University of Jerusalem, Jerusalem, Israel).

A total of 2950 hospital visits of incarcerated individuals were documented during the study period. Patients were shackled in 2812 (95.3%) of these visits (appendix pp 1–2). Patients were accompanied by guards for all visits (n=1078 with available data; 518 [48.1%] with two guards and 442 [41.0%] with three or more guards). When the type of visit was known (n=2849), shackling proportions were similar between outpatient visits (2249 [95.8%] of 2347) and inpatient visits (470 [93.6%] of 502). Outpatients most often had both hands and legs shackled (1752 [87.0%] of 2013 visits with available data; appendix p 1). In at least 258 (51.4%) of the 502 inpatient visits, the patients

were shackled to the bed, although this might be an underestimation given that detailed information on the shackling method was absent for some inpatients (appendix p 1). In 155 visits, inpatients were restrained to the bed with two oblique short shackles on an opposite arm and leg, preventing their movement during the hospital stay, representing 79.9% of 194 inpatient visits in which the patient was shackled to the bed and the shackling position was known (appendix p 1).

We found no difference in the proportion of patients shackled between children younger than 18 years (77 [95.1%] of 81 visits) and adults (1138 [93.0%] of 1224 visits). However, the proportion was lower for incarcerated patients older than 65 years (38 [80.9%] of 47 visits; estimated common odds ratio 3.3 [95% CI 1.31–7.60] vs incarcerated patients aged ≤65 years, p=0.0058, stratified Fisher's exact test). Shackling proportion was similar between patients who were arrested due to a criminal offence (748 [94.8%] of 789 visits) and those arrested for a security offence (558 [91.0%] of 613 visits). However, data regarding age and arrest background should be interpreted with caution as they were only collected by some hospitals and may thus be subject to selection bias (appendix p 2).

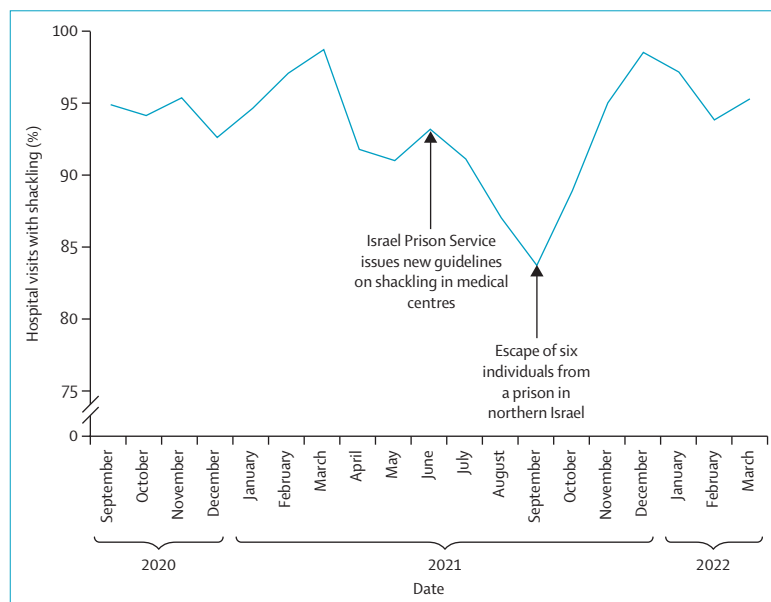
Severely impaired mobility for medical reasons was documented in 106 visits, and in 89 (84.0%) of these visits, patients were shackled regardless, including those who had received major surgery, ventilated patients, and those with severe orthopaedic conditions. We documented demands from guards to be present in the operating theatre and during other major medical procedures.

To raise public awareness about this problem, we published part of our data locally in a Hebrew language medical journal,<sup>8</sup> as well as in social and print media. This information was also distributed by mass communications to physicians and nurses in Israel, with an emphasis on their ethical obligation



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See Online for appendix



**Figure:** Hospital visits with shackling during the national intervention programme (September, 2020–March, 2022)

Data collected between January and August, 2020, were not categorised by month and are not included.

to intervene. We then proposed a national action plan, which comprised, among other initiatives, meetings with major policy stakeholders including the security bodies, the Israeli Ministries of Justice, Health, and National Security, and members of parliament to discuss shackling protocols and alternative security measures.

Through the Nursing Division of the Ministry of Health, we have been successful in encouraging a nationwide change, such that hospitals are now starting to routinely document shackling in a standardised data field in electronic medical records. In extreme cases when the shackling was clearly unnecessary for medical reasons (eg, for patients with amputated legs or other major health conditions), we have appealed to the courts. Additionally, we initiated an innovation competition for physicians, product designers, and engineers to develop technological solutions that ensure security while minimising the use of shackling. Two of the winning solutions are currently under development. While presenting our data before the Internal Security Committee of the Israeli parliament, the IPS commented that the shackling we

documented was not in keeping with local regulations and expressed their commitment to make improvements.

In parallel with our monitoring and national intervention activities, we found that shackling proportions began to gradually decrease, with a major decrease from June, 2021, when, as a result of our discussions, the IPS issued updated regulations on the shackling of incarcerated people in medical centres (figure). The decrease in shackling reached a minimum of 77 (83.7%) of 92 visits in September, 2021, but then sharply increased in association with the escape of six incarcerated individuals from a prison (not a medical facility) in northern Israel (from Gilboa Prison on Sept 6, 2021), which triggered a public backlash against the security authorities.

To the best of our knowledge, this study is the first in English literature to provide quantitative data on the extent of shackling of incarcerated individuals in medical centres. A full discussion on the balance between security and human rights in the hospital setting is beyond the scope of this piece, but can be found elsewhere.<sup>9</sup> In brief, these considerations include the right

to security and safety on the part of society and medical teams, versus the right of all patients to be treated with dignity. In addition, shackling during a hospital stay poses the possibility of physical injury, such as handcuff neuropathies,<sup>10</sup> the risk of pulmonary embolism,<sup>11</sup> and pressure ulcers.<sup>12</sup> The sight of shackles can also lead to the patients being perceived as dangerous, which can negatively affect the degree of empathy and quality of medical care offered to these patients, which can, in turn, undermine their trust in medical decisions.<sup>1,13</sup> Immobilisation caused by shackling to the bed, particularly in the commonly used oblique position, is associated with extreme pain and discomfort, which might become intolerable during a prolonged hospital stay. Indeed, in our cohort, several incarcerated individuals refused hospitalisation in favour of returning to prison where they would be free of shackles.

The results obtained in our monitoring programme are country-specific. However, similar to Israel, there are other countries that have individual risk assessment-based shackling regulations, such as Australia, New Zealand, and the UK.<sup>14,15</sup> Indeed, more than 50 viewpoint manuscripts from a variety of countries have expressed concerns regarding unselective shackling of incarcerated people in hospitals,<sup>5-7</sup> suggesting that this is a matter that clinicians across the globe find troubling. Despite these concerns, reports dedicated to the health of incarcerated individuals, such as the Health in Prisons European Database surveys, do not have information regarding shackling practices during medical care.

With its basis in a national survey, we present an intervention programme with implementation principles geared towards facilitating, as much as possible, the equal and dignified management of incarcerated patients. Since in-hospital shackling of incarcerated individuals seems to be an unresolved issue worldwide,

For the **New Zealand regulations** see [https://www.corrections.govt.nz/resources/policy\\_and\\_legislation/Prison-Operations-Manual/Movement/M.04-External-movement-transportation-of-prisoners/M.04.01-Prisoner-escorts-transfers-general](https://www.corrections.govt.nz/resources/policy_and_legislation/Prison-Operations-Manual/Movement/M.04-External-movement-transportation-of-prisoners/M.04.01-Prisoner-escorts-transfers-general)

For the **Health in Prisons European Database** see [https://www.who.int/data/region/europe/health-in-prisons-european-database-\(hiped\)](https://www.who.int/data/region/europe/health-in-prisons-european-database-(hiped))

For the **innovation competition** see <https://www.bezalel.ac.il/news/3022> (in Hebrew)

it is paramount for health-care professionals to be familiar with this matter, both in terms of local and international regulations, as well as its medical and ethical aspects. The sharp increase in shackling proportions after the escape of six incarcerated individuals in Israel highlights the unfortunate reality that policy in this area is often driven by so-called knee-jerk politics rather than by evidence. Therefore, embedding of shackling data into electronic medical records is a cornerstone in promoting transparency and accountability. What cannot be measured cannot be improved, and our findings highlight the effectiveness of rigorous documentation to power change.

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