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Health Rights in the Balance: The Case Against Perinatal Shackling of Women Behind Bars

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Brett Dignam and Eli Y. Adashi

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Abstract

Rationalized for decades on security grounds, perinatal shackling entails the application of handcuffs, leg irons, and/or waist shackles to the incarcerated woman prior to, during, and after labor and delivery. During labor and delivery proper, perinatal shackling may entail chaining women to the hospital bed by the ankle, wrist, or both. Medically untenable, legally challenged, and ever controversial, perinatal shackling remains the standard of practice in most US states despite sustained two-decades-long efforts by health rights legal advocates, human rights organizations, and medical professionals. Herein we review the current statutory, regulatory, legal, and medical framework undergirding the use of restraints on pregnant inmates and explore potential avenues of redress and relief to this challenge. We also recognize the courage of the women whose stories are being told. If history is any guide, the collective thrust of domestic and international law, attendant litigation, dedicated advocacy, and strength of argument bode well for continued progress toward restraint-free pregnancies in correctional settings.

Introduction

In 1994, Women Prisoners of District of Columbia Department of Corrections v. District of Columbia first upheld a challenge to perinatal shackling of pregnant inmates.[1] The widespread practice did not become more broadly recognized until 1999, when Amnesty International released the report *Not part of my sentence: Violations of the human rights of women in custody.*[2] A second Amnesty International report, released in 2001 and entitled *Abuse of women in custody: Sexual misconduct and shackling of pregnant women* removed any lingering doubts as to the legality of the practice.[3] Herein we review the current statutory, regulatory, legal, and medical framework undergirding the use of restraints on pregnant inmates and explore potential avenues of redress and relief to this challenge.

Correction by the numbers

After three decades of extraordinary growth (1980–2009), fueled by harsh

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mandatory sentencing and release policies, well over 7 million—1 in every 34—adult US men (82%) and women (18%) became by 2009 the subject of correctional jurisdiction be it jail, prison, probation, or parole.[4] No other developed or developing nation comes close.[5] Adjusted for growth in the adult population, the latest (2011) national correctional census is three times the size of its 1980 counterpart.[6] With 2.3 million (1 in every 102) adults behind federal, state, and jail bars, the national incarceration rate has soared to 983 per 10,000 adults.[7] With juvenile, territorial, military, and Indian country inmates accounted for, the national population in custody is 2.4 million (1 in every 95) adults. This brings the national incarceration rate to 1,049 per 10,000 adults.[8] While federal and juvenile facilities are home to some of the nation's inmates (8% and 4%, respectively), state prisons and local jails shoulder most of the burden (55% and 33%, respectively).[9]

Female offenders

Women were not spared. In recent years (1990–2009), 1.3 million women (1 in 92) were under custodial or community-based correctional sanction.[10] Of those, 198,600 (15%) were confined behind federal, state, and jail bars for an incarceration rate of 167 per 10,000 adult women.[11] While women only account for 9% of the incarcerated population, the 5% average annual growth rate of the female inmate census over the last two decades has outpaced that of men (3.6%).[12]

Pregnancy behind bars

Accurate figures on the prevalence and incidence of pregnancy behind bars are unavailable, given inconsistent reporting requirements and pregnancy testing upon admission to jail or prison. Published accounts are sparse. In 1995, Breuner and Farrow—relying on a national survey of juvenile facilities—reported an annual census of 2,000 pregnant adolescents behind bars.[13] A 1999 study of the California juvenile justice system listed a 16% incidence of pregnancy among female inmates.[14] That same year, a survey by the American Correctional Association (ACA) noted a total of 1,900 pregnant inmates and 1,400 births in prisons and jails during the year under study.[15] Several subsequent reports from the Centers for Disease Control and Prevention and the Bureau of Justice Statistics, spanning 1994–2008, placed the incidence of pregnancy upon admission at 3–10%.[16] As such, these figures imply present-day prevalence rates of 6,000 to 20,000 pregnant inmates annually in the nation's jails and prisons.[17] Often high risk in nature, the pregnancies under discussion are marked by limited or absent prenatal care, suboptimal nutritional support, substance and/or alcohol abuse, environmental and/or domestic violence, and sexually and/or parenterally transmitted diseases.[18]

Perinatal shackling: The statutory and regulatory framework

Designed for male offenders, the US correctional system is still working through the adjustments required to accommodate an ever-growing cohort of female inmates. Nowhere is this reality more apparent than during pregnancy and parturition.[19] Nowhere is the tension more palpable than in the case of perinatal shackling.[20] Rooted in security concerns ascribed to offsite medical care, perinatal shackling is the default correctional solution to public safety, officer protection, and flight risk.[21] As such, extensive—indeed continuous—perinatal shackling is an outgrowth of a gender-blind policy which has been extended to include pregnant women before, during, and after delivery. In effect, parturient women are being ascribed the same security and flight risk as are their non-pregnant counterparts without regard to prior history of violence or escape attempts. As such, this practice runs counter to the fact that female inmates commit less violence and less serious violence than male counterparts.[22]

Until relatively recently (2000), individual wardens and jailers had the authority to impose perinatal restraints, given the absence of federal or state statutes.

However, on January 1, 2000, Illinois broke the mold: the state legislature amended the Unified Code of Corrections to prohibit perinatal shackling during hospital transport and delivery.23 The statute mandated that "when a pregnant female prisoner is brought to a hospital…for the purpose of delivering her baby, no handcuffs, shackles, or restraints of any kind may be used. Under no circumstances may leg irons or shackles or waist shackles be used on any pregnant female prisoner who is in labor."[23] By mid-2013, 17 other states had followed suit (Arizona, California, Colorado, Delaware, Florida, Hawaii, Idaho, Louisiana, Nevada, New Mexico, New York, Pennsylvania, Rhode Island, Texas, Vermont, Washington, and West Virginia).

Federal legislative and regulatory initiatives soon followed. On April 9, 2008, President George W. Bush signed the Second Chance Act of 2007 into law, thereupon requiring that all federal correctional facilities document, report, and justify on security grounds the use of physical restraints on pregnant inmates before, during, and after labor and delivery.[24] The law further mandated that the "Attorney General shall submit to Congress a report on the practices and policies of agencies within the Department of Justice relating to the use of physical restraints on pregnant female prisoners during pregnancy, labor, delivery of a child, or post-delivery recuperation."[25] Properly implemented, data collection could prove central to the enforcement of the policies in question. As written, the law does not apply to detainees of US Immigration and Customs Enforcement (ICE), which reports to the Department of Homeland Security.

Concurrently, federal law enforcement agencies developed policies that reinforced this legislation. In October 2007, the US Marshals Service (USMS) revised its restraint policies, all but eliminating the shackling of pregnant federal pretrial detainees and inmates, unless deemed necessary by compelling security considerations.[26] That the policy stated that "restraints should not be used when compelling medical reasons dictate, including when a pregnant prisoner is in labor, is delivering her baby, or is in immediate post-delivery recuperation."[27] Special emphasis was placed on the use of the least restrictive constraints "to ensure safety and security."[28] Shortly thereafter, the Federal Bureau of Prisons (BOP), home to 14,000 federal female inmates, amended its policy to bar the shackling of pregnant inmates in labor, delivery, or post-delivery recuperation "unless there are reasonable grounds to believe the inmate presents an immediate, serious threat of hurting herself, staff or others, or there are reasonable grounds to believe the inmate presents an immediate and credible risk of escape that cannot be reasonably contained through other methods."[29] The policy also indicated that an inmate who is restrained while in labor (or while delivering her baby), the restraints must be "the least restrictive restraints necessary to still ensure safety and security."[30] More recently, ICE has adopted some of the same principles in its operations manual of performance-based national detention standards.[31]

Collectively, these new state and federal measures represent significant progress during the last decade. Still, the benefits apply only to one-third of the nation's women inmates. Relief for the remaining two-thirds depends on the enactment of relevant statutes by the 31 states and the District of Columbia now lacking such legislation. Until that occurs, a confusing patchwork of state and local administrative policies—written and unwritten—will prevail.

Perinatal shackling and US case law

Documented legal challenges to perinatal shackling have been emblematic of the indispensable role of litigation in the defense of human rights. Common to the majority of these cases has been the reliance on the Eighth Amendment to the United States Constitution, a provision that prohibits "cruel and unusual punishment" and that is informed by contemporary standards of decency. The standards for evaluating Eighth Amendment claims have been defined by the United States Supreme Court in Farmer v. Brennan.[32] For example, the standard

of “deliberate indifference to serious medical needs” is most frequently applied to medical claims. In a closely watched recent case involving a class of prisoners presenting serious medical claims in Brown v. Plata, the United States Supreme Court acknowledged “deliberate indifference to serious medical needs” as the governing standard but also applied a standard of “deliberate indifference to a substantial risk of serious harm.”[33] Both standards accord deference to the clinician who evaluates “serious medical need” or “serious harm,” as demonstrated in court cases that challenge perinatal shackling.

A 1993 class action suit by women inmates against the District of Columbia (Women Prisoners of District of Columbia Department of Corrections v. District of Columbia) was the first to challenge several correctional practices, including that of perinatal shackling.[34] In an important and comprehensive decision, Federal District Judge June L. Green struck down the practice of shackling women prisoners during labor. In so doing, the court concluded:

> *[The] plaintiffs have demonstrated that the manner in which the Defendants shackle pregnant women prisoners in the third trimester of pregnancy and immediately after delivery poses a risk so serious that it violates contemporary standards of decency. The Court understands that the Defendants may need to shackle a woman prisoner who has a history of assaultive behavior or escapes. In general, however, the physical limitations of a woman in the third trimester of pregnancy and the pain involved in delivery make complete shackling redundant and unacceptable in light of the risk of injury to a woman and baby. The Court believes that leg shackles adequately secure women prisoners without creating an inhumane condition of confinement during the third trimester. While a woman is in labor and shortly thereafter, however, the Court holds that shackling is inhumane.*[35]

Although the Court of Appeals vacated and modified parts of the District Court’s opinion when deciding Women Prisoners of District of Columbia Department of Corrections v. District of Columbia, the lower court’s opinion on the matter of perinatal shackling was not challenged.[36] No other cases were tried successfully until 2009. While the reasons behind this 16-year lull remain uncertain, newly imposed constraints on the ability of prisoners to bring claims challenging the conditions of their confinement may be at play.[37]

More recently, in a closely watched case, Nelson v. Correctional Medical Services, a deeply divided Eighth Circuit Court of Appeals vacated an earlier appellate panel opinion thereby holding that a prisoner had a clearly established constitutional right not to be shackled, absent clear and convincing evidence that she was a security or flight risk.[38] The court’s explication of the factual background established that Nelson, who did nothing to suggest that she was a threat or a flight risk, was shackled during transport to the hospital as well as at the hospital (to both sides of the bed). While in labor, Nelson was unshackled and reshackled each time the medical staff measured cervical dilation. It was only at the request of the attending obstetrician that the shackles were removed before she went into the delivery room. Relying on Farmer v. Brennan and referring to the “failure to protect” and “serious medical need” standards, the majority noted that “[a] prison official is deliberately indifferent if she ‘knows of and disregards’ a serious medical need or a substantial risk to an inmate’s health or safety.”[39] Turning to the medical claim, the court found that Estelle v. Gamble had established that “either interference with care or infliction of ‘unnecessary suffering’ establishes deliberate indifference in medical care cases in violation of the Eighth Amendment.”[40] The court also noted that the “precise issue” had been decided in Women Prisoners of the District of Columbia Department of Corrections v. District of Columbia and that the constitutional holdings were never appealed by the government, and remained in effect when

Nelson was in labor.[41] Summarizing its analysis, the court concluded:

> *Existing constitutional protections, as developed by the Supreme Court and the lower federal courts and evidenced in [prison] regulations, would have made it sufficiently clear to a reasonable officer in September 2003 that an inmate in the final stages of labor cannot be shackled absent clear evidence that she is a security or flight risk.[42] Indeed, "[t]he obvious cruelty inherent in this practice should have provided [the correctional officer] with some notice that [her] alleged conduct violated [Nelson's] constitutional protection against cruel and unusual punishment. [Nelson] was treated in a way antithetical to human dignity … and under circumstances that were both degrading and dangerous.[43]*

Finally, relying on the analytic framework constructed in Nelson v. Correctional Medical Services, a federal district court in Washington State held in Brawley v. Washington that "…shackling inmates while they are in labor was clearly established as a violation of the Eighth Amendment's prohibition against cruel and unusual punishment."[44] Some of the same imperatives were operational in the more recent Villegas v. Metropolitan Government of Davidson County which held that the "shackling of a pregnant detainee in the final stages of labor shortly before birth and during the post-partum recovery" violates the Eighth Amendment.[45]

Perinatal shackling and international human rights law

Lacking controlling authority in the courts of sovereign nations, international human right instruments must not be construed as an extension of national legal constructs. Instead, conventions and treaties are best viewed as international bellwethers of collectively accepted standards and norms. Considered in this light, international consensus can in fact exert significant—if indirect—effect on the policies and laws of member nations worldwide. Similar, if more muffled, conclusions apply to foreign laws.

In 1998, prompted in part by Women Prisoners of District of Columbia Department of Corrections v. District of Columbia, the practice of perinatal shackling in the US had been reviewed by the United Nations Special Rapporteur on violence against women, its causes and consequences.[46] Specifically, Radhika Coomaraswamy, the first Special Rapporteur on violence against women, visited prison facilities in seven states and the District of Columbia. The resultant 1999 report concluded that "the use of these instruments [of restraint] violates international standards and may be said to constitute cruel and unusual practices."[47]

With the 1999 report Not Part of My Sentence: Violations of the Human Rights of Women in Custody, Amnesty International advanced the position that perinatal shackling, while not a violation of US criminal laws, was nevertheless in "direct violation of international standards such as the UN Standard Minimum Rules for the Treatment of Prisoners."[48] The latter instrument, first introduced in 1955, all but prohibits the use of "instruments of restraint" on prisoners while requiring that prisons make special accommodations for the care and treatment of pregnant women.[49] In May 2000, seeking to extend its claim, Amnesty International proceeded to submit a briefing to the UN Committee Against Torture, which monitors compliance with the UN Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment.[50] In its briefing, Amnesty International restated that it "remains common for restraints to be used on pregnant women prisoners when they are transported to and kept at the hospital, regardless of their security status."[51] In its consideration of reports submitted by States Parties under Article 19 of the Convention, the UN Committee against Torture expressed concern about the US practice according to which "Female detainees and prisoners…[are] held in humiliating and degrading

circumstances."[52]

In 2005, a collaborative comprised of the Criminal Justice Policy Foundation, Open Society Policy Center, Penal Reform International, and the Sentencing Project submitted a shadow report to the UN Human Rights Committee, which monitors implementation of the UN's International Covenant on Civil and Political Rights (ICCPR).[53] In the report, the groups contended that "women [prisoners] are especially at risk for…inadequate medical and obstetric care, including shackling during childbirth."[54] In its concluding observations, the UN Human Rights Committee went beyond registering its concern about the "shackling of detained women during childbirth" to issue a recommendation that the US prohibit the practice if it is to be ICCPR-compliant.[55]

In 2006, yet another shadow report was submitted to the UN Committee Against Torture for its consideration.[56] Originating with the International Gender Organization, the report, Women in the Criminal Justice System: Longitudinal Systemic Abuse, espoused restriction of the use of shackles to all but the rarest of circumstances.[57] In its comments, the Committee Against Torture noted its concerns with "incidents of shackling of women detainees during birth" and made the recommendation that the US "adopt all appropriate measures to ensure that women in detention are treated in conformity with international standards."[58]

As recently as 2011, Rashida Manjoo, the current Special Rapporteur on violence against women, its causes and consequences, expressed ongoing concerns after visiting five states and the District of Columbia.[59] Special emphasis was placed on the apparent failure of the Department of Homeland Security and ICE to finalize its draft policy on detention standards and to promulgate them through a regulatory paradigm. Resultant recommendations included a call to "Adopt legislation banning the use of restraints on pregnant women, including during labor or delivery, unless there are overwhelming security concerns that cannot be handled by any other method."[60]
Finally, note is made of the fact that the practice of perinatal shackling is incongruent with administrative policies of nations with whose language, culture, and laws the US is closely aligned. For example, the Prison Service of England and Wales precludes the shackling of pregnant inmates requiring offsite medical care absent extenuating circumstances.[61] Comparable administrative policies have been advanced by Her Majesty's Chief Inspector of Prisons in Scotland.[62]

Perinatal shackling: Medical considerations

Careful consideration of the medical impact of perinatal shackling reveals a multiplicity of potential risks. The antepartum application of leg irons to mothers-to-be may cause imbalance while walking and thus increase proneness to falls.[63] In that context, concurrent handcuffing may prevent a woman from breaking a fall and avoiding injury. Intrapartum shackling poses additional challenges. Preventing walking during the first stage of labor may deny the woman the benefits of labor acceleration and discomfort alleviation.[64] Preventing walking during the postpartum phase may enhance the risk of deep vein thrombosis and its life-threatening embolic complications.[65] In addition, restricting maternal repositioning precludes relief from aortocaval compression in the face of fetal distress or maternal hypotension.[66] Maternal immobilization in the supine position also compromises the administration of epidural anesthesia. Perhaps most importantly, constrained maternal positioning undermines delivery in cases of cephalopelvic disproportion (CPD) or shoulder dystocia.[67] Shackling throughout the four stages of labor may also impede the rapid transition to an emergency cesarean section if required.

In support of the aforementioned concerns, many national and international medical organizations have gone on record to oppose perinatal shackling. The American Congress of Obstetrics and Gynecology (ACOG), a leading association

of over 50,000 providers concerned with women's health, was first to register its disapproval, in 2007. ACOG noted: "Physical restraints have interfered with the ability of physicians to safely practice medicine by reducing their ability to assess and evaluate the physical condition of the mother and the fetus."[68] Also in 2007, the World Health Organization (WHO) stated: "There must be a complete bar on the use of shackling during labor."[69] In 2009, the American Correctional Health Services Association (ACHSA)[70] noted that it "supports banning the use of leg irons/shackles and restraints for pregnant women during labor and delivery and immediately after they have given birth." As recently as 2010, the American Medical Association (AMA), the largest association of physicians in the US, unanimously adopted Resolution 203 (Shackling of Pregnant Women in Labor) to prohibit shackling before, during, and after delivery.[71] Also in 2010, the Board of Directors of the National Commission on Correctional Health (NCCHC), the accrediting agency of correctional health services, adopted a position statement on the matter of perinatal shackling.[72] Finally, note is made of the recently issued Position Statements of the Association of Women's Health, Obstetric & Neonatal Nursing (AWHONN) and of the American College of Nurse Midwives (ACNM).[73] Weighing in on the challenge of perinatal shackling, both organizations went on record to all but ban the practice.

Perinatal shackling: The power of advocacy

While lacking the force of law, the impact of regulatory dictates, or the moral consensus of international instruments, a substantial number of key advocacy organizations are on record on the matter of perinatal shackling. As early as 2003, the Task Force on Correctional Health Care Standards of the American Public Health Association (APHA; the oldest national organization of public health professionals) updated its Standards for Health Services in Correctional Institutions to state that women "must never be shackled during labor and delivery."[74] In 2008, the Standards Committee of the American Correctional Association (ACA) approved a new standard and written policy to "prohibit the use of restraints on female offenders during active labor and delivery of a child."[75] Two 1999 reports issued by Human Rights Watch and the Florida Immigrant Advocacy Center addressed the plight of pregnant detainees, calling on ICE to prohibit the shackling of pregnant women. As recently as 2010, the House of Delegates of the American Bar Association (ABA) unanimously resolved to adopt Standard 23-6.9 (Pregnant Prisoners and New Mothers) on shackling pregnant women, noting that "a prisoner should not be restrained while she is in labor, including during transport, except in extraordinary circumstances."[76] Lastly, note must be made of steadfast advocacy by the National Organization for Women (NOW) whose call to "End Shackling Now" has been broadly heeded.[77]

Perinatal shackling: The challenge of ban implementation

As is broadly appreciated, the passage of a statute, while necessary, is not sufficient to ensure its implementation. State-legislated bans on perinatal shackling are not exempt from this perennial challenge. Examples abound. The State of Illinois, the first to ban perinatal shackling, has recently signed into law an amending bill, 55 Ill. Comp. Stat. 5/3-15003.6 (2012), designed to clarify and strengthen its own 12-year-old statute.[78] Backed by an advocacy consortium headed by the American Civil Liberties Union (ACLU) and the Chicago Legal Advocacy for Incarcerated Mothers (CLAIM), HB 1958 was introduced to address alleged ongoing violations of the original if imperfect law. Examples of relevant (successful) litigation include but are not limited to Zaborowski v. Dart, which raises a novel Fourteenth Amendment substantive due process claim.[79] Similar concerns have been raised in Texas. A recent ACLU review of the six largest jails in Texas "brought into sharp focus the uneven implementation of the Shackling Ban and the Pregnant Inmate Care Standards."[80] More recently, California, prompted in large measure by slow implementation of a narrowly crafted statute, signed AB 2530 into law, thereby extending an existing peripartum shackling

ban to cover the entire duration of pregnancy.[81] Similar issues may well arise in many, if not all, of the other states in which a shackling ban statute is currently in effect. Such ongoing efforts may well be inevitable if sustained lasting changes of current practices are to be realized.

Perinatal shackling: The road ahead

At the time of writing, additional statutory relief in the matter of perinatal shackling is not likely to occur at the federal level. A newly legislated stand-alone federal ban on perinatal shackling is deemed unlikely in the face of restrictions presently imposed by the Second Chance Act of 2007 and recent revisions of USMS, BOP, and ICE policies. Whether or not a potential federal initiative might ultimately be incorporated into long overdue correctional reform legislation remains uncertain and cannot be ruled out. Given present-day priorities, it appears unlikely that national correctional reform will rise to the top of the congressional legislative agenda anytime soon.

The prospect of prosecutorial relief at the federal level, one enabled by the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA), is viewed as equally unlikely.[82] Designed, in part, to protect the rights of inmates in state or local correctional facilities, the law is enforced by the Special Litigation Section of the US Department of Justice (DOJ) Civil Rights Division. Arguing violation of CRIPA, the Attorney General could, in principle, bring systemic challenges to state practices wherein perinatal shackling is perpetuated. Such prosecution would likely rest on the argument that the practice constitutes deliberate indifference to a serious medical need or is a failure to protect from a substantial risk of serious harm in violation of a pregnant inmate's Eighth Amendment right not to be subjected to cruel and inhumane punishment. The feasibility of CRIPA-driven prosecution by the DOJ notwithstanding, the paucity of precedent in the course of the last 30 years raises significant doubts as to the materialization of this possibility.

More likely than not, statutory relief in the matter of perinatal shackling will be achieved at the state level. This prediction is supported by the fact that 18 states have enacted relevant legislation in the last decade. Spurred by dedicated advocacy and legal challenges, progress will likely continue. Indeed, several states are entertaining new legislation that would limit perinatal shackling (e.g. Connecticut, Massachusetts, Iowa, Georgia, New Jersey, Oregon, Virginia, New Hampshire, and Tennessee). In this regard, the powerful advocacy of the state-by-state "Report Card" issued by the Rebecca Project for Human Rights cannot be overemphasized.[83] Regrettably, a few states have defeated similar bills. However, even when legislation is defeated, legislative debates have prompted regulatory change. For example, the sponsor of the defeated Virginia bill announced that the Department of Corrections will promulgate regulations prohibiting the use of restraints on pregnant prisoners during labor, delivery and postpartum recovery.[84] All indications are that the process required to approve the proposed regulations is well under way.[85] Moreover, it is possible that the final product will include all important "strong public reporting requirement… to ensure accountability for and compliance with the regulations."[86] A similar evolution may be well under way in Iowa in response to Senate Bill SF 134.[87]

Going forward, efforts to roll back perinatal shackling will likely rely on its moral, medical, and legal vulnerability.[88] Incompliant with international instruments such as CAT and ICCPR, and likely the Standard Minimum Rules for the Treatment of Prisoners, the UN has repeatedly rebuked the practice.[89] Similar concerns have been raised by failure to comply with standards of medical care set forth by leading national and international health organizations such as ACOG, WHO, ACHSA, AMA, NCCHC, AWHONN, ACNM, and APHA.

Above and beyond formal considerations, perinatal shackling must also be evaluated by its impact on a woman's birth experience. Indeed, by its very nature, the practice of perinatal shackling runs counter to the expectation of

birth with dignity. Instead, descriptors such as demeaning, humiliating, and traumatizing have been promulgated. If history is any guide, the collective thrust of dedicated advocacy, the strength of its argument, the broad national and international support, and the growing momentum, bode well for ongoing progress toward a restraint-free pregnancy in the correctional setting.

***Brett Dignam**, MA, JD, is Professor of Law at Columbia Law School, Columbia University, New York, NY, USA.*

***Eli Y. Adashi**, MD, MS, is Professor of Medical Science at The Warren Alpert Medical School, Brown University, Providence, RI, USA.*

Please address correspondence to Eli Y. Adashi. Email: Eli_Adashi@brown.edu.

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