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Isolated & Imprisoned:
An Ethical Discussion of Reproductive Rights for Incarcerated Women

I. Introduction

Richard Singer (1971) states, "…the concepts of privacy and prison are antithetical beyond comprehension."

From the moment a person enters prison, their autonomy and identity are stripped. The prison system functions on their own rights, which eliminates certain constitutional rights such as that of privacy. Thus, any person seeking healthcare in prison has to confront the notion they are both patient and prisoner, and any practitioner providing healthcare has to confront this conflict of duty.

Based on Beauchamp and Childress' definition of autonomous healthcare practice, prisons, having little ability and respect for the balance of autonomy, provide unethical healthcare to pregnant inmates (2013). Beauchamp and Childress (2013) suggest health-care professionals are expected to speak truthfully, protect privacy and confidentiality, obtain consent, help in decision-making when asked, and establish a trustworthy physician-patient relationship. Using studies conducted by healthcare professionals and bioethicists of incarcerated patients, the following paper will assess common prison practices at the prenatal stage, during labor and delivery, and postpartum.

The goal of the following research is to: (1) assess the legal policies that have been established and have set the precedent for the current state of reproductive healthcare for incarcerated people; (2) explore the current practices of incarcerated women who are pregnant at the time of imprisonment; (3) discuss the ramifications off the current practices on women of color and their children.

II. Relevant Legal History

BUCK V. BELL, 274 U.S. 200 (1927)

Carrie Buck was an inmate of Virginia States Colony for Epileptics and Feebleminded. Buck was considered to be Feebleminded, with the condition also affecting the previous two generations. In October of 1927, Bell was ordered to and under went a surgery to sterilize her. In Virginia, the mandatory sterilization was legal under the Racial Integrity Act of 1924 and the Commonwealth of Virginia's eugenics program. The only requirement was a hearing to determine whether the sterilization was appropriate for the inmate.

The issues that arise from the case concern the constitutional right to a due process and of equal protection, under the Fourteenth Amendment.

The court found the Virginia statue was not unconstitutional. The requirements of the statute was enough to satisfy the court. Per the statute, the inmate had the right to a hearing an could request the Court of

Appeals to review the orders, if necessary, and a guardian does have the option to attend the hearing, a process which requires months of review. Justice Holmes stated the issue Buck had was not with the sterilization but with the lack of due process prior to the operation. With the explanation of the extent of the process, Justice Holmes also stated it was in the best interest for the nation not to be overwhelmed with "incompetence" and his infamous statement, "…Three generations of imbeciles are enough."

Since the ruling in 1927, Buck v. Bell has not been overturned. In fact, recent cases since its ruling have concluded forced sterilizations are not always unconstitutional.

ESTELLE V. GAMBLE (1976)

Almost fifty years later, in the case of Estelle v. Gamble, Gamble, an inmate of a prison facility, again challenges the healthcare practices conducted. The issue at hand in the Estelle v. Gamble case became a question of was the substandard medical care provided a violation of Gambles constitutional rights and was it rightfully reversed.

SCOTUS held that the medical care given did not violate Gamble's constitutional rights as provided by the Eighth Amendment.

Justice Thurgood Marshall stated under the Eighth and Fourteenth Amendments, the state of Texas must provide medical care for inmates. The quality of the care however is not explicitly stated. Also, the choice of the care given is up to the discretion of the physician. Because the physician decided certain processes were not medically necessary did not equate to unconstitutional medical treatment. The ruling in this case establishes the requirements for prisoners' medical rights under the Eighth Amendments. Going forward in the future, in order to claim mistreatment, deliberate indifference or injury which constitutes as cruel and unusual punishment would have to be proven.

These standings still govern the health practices of medical institutions and prisons today. In fact, as the government challenges the necessity of the reproductive rights of non-incarcerated women, they simultaneously add to the layers upon layers of reproductive restrictions of incarcerated women.

III. Reproductive Practices Incarcerated Women in the US

We now turn to a discussion of the current and published practices studied in various prisons in the United States beginning with prenatal care, moving to labor and delivery and finishing with common postpartum practices. These three areas require positive and appropriate ethical healthcare, as the negative effects can be detrimental, leading to death, birth defects, and increased depression in mothers and children.

Prenatal Care

Typical, prenatal care consists of regular checkups to monitor the growth of the pregnancy, assess the health of the mother and screen for possible genetic problems. In a research conducted by, Ferszt and Clarke (2012), they reported twelve of the nineteen prisons they studied transported prenatal inmates out to local hospitals for care, and in 2016, Fritz and Whiteacre studied the effects of both in-house

prenatal care at prisons and off-site care. Fritz and Whiteacre (2016) found little difference between the off-site care and standard in-prison protocol. It was reported in numerous visits, mothers received regular prenatal visits to discuss the sex and development of their pregnancies, with little additional counseling regarding vital topics such as childbirth or parenting. In the two group studied, Fritz and Whiteacre (2016) reported little communication, feelings of de-personalized healthcare, and failure to respond promptly to patient requests.

Although the issues reported are not foreign to the experiences of minorities in the healthcare system in general, two factors add to prison substandard care: (1) the ruling in Estelle v. Gamble determines little standard of care and that neglect must be proven; (2) the prison setting presumes punishment, therefore lack of regard is exacerbated. The reported prenatal care exemplifies the failure to educate prenatal patients on the critical steps and status of their pregnancy, in order to avoid harmful outcomes. It is unethical for physicians to withhold information relevant to the autonomous decision making of patients. Patients should be provided updates such as the due date in order to make sound decisions like the decision to continue or not. Factors such as history of drug-use and stress can contribute to the negative development of a pregnancy. The rate of both factors are higher in prison, therefore, pregnant inmates are likely to have more complicated pregnancies which require complex healthcare solutions. Pregnant inmates do not have the liberty to choose their physician, therefore they are left to rely solely on the information provided by their prison clinician. Knowing these stressors, clinicians have the ethical duty to provide beneficial and thorough individualized care so that incarcerated pregnant patients can make informed decisions when confronted with complex questions. Information should be made available both in group prenatal meetings to mitigate costs, and/ or in routine visits to the facility OB/GYN.

Labor & Delivery

Following months of recurring visits to prison OB/GYNs, pregnant inmates are induced into labor. An assessment of common labor and delivery practices in prisons, prove practitioners fail to provide ethical healthcare in three areas negatively impacting the autonomy of the patient: (1) respecting patient's needs and decisions; (2) maintaining patient privacy and; (3) exercising unnecessary physical restraint. What follows explains the experiences reported by pregnant and incarcerated patients during their deliveries.

Delivery in major hospitals encourage labor support, otherwise known as birth coaches, usually a spouse or female relative. Additionally, depending on the hospital, one to three other relatives may also be present. Pregnant inmates are similarly given the option to invite one birth coach to their delivery. However, per Fritz and Whiteacre (2016), more than half of the patients reported having no birth coach at their delivery. These absences were due to prison staff failing to communicate in advance with inmates regarding delivery dates, communicating too late for birth coaches to travel to the birth in time, or declining to notify birth coaches. According to inmates, many of the mothers are induced, with prison healthcare providers aware of the delivery date in advance but making little or no attempt to contact their birth coach.

Often without support, prison policy mandates women must remain in restraint well into the delivery. However, the priority of security over the safe delivery of patients is a concern of practitioners. Ferszt

and Clarke (2012) found six of the nineteen prisons used restraint during birth, eight during labor, and two in transportation. Restraints consisted of devices from belly chains and belts to handcuffs and leg irons, as well as, guards whom were allowed to remain in the delivery rooms. It was reported, between 40% and 58% of pregnant inmates reported the restraints as negative and traumatizing (Ferszt & Clarke, 2012). The use of restraint well into the delivery process negatively affects patient autonomy because it undermines the patient-physician relationship.This is concerning because it puts a patient in a state of duress. Thus, women are not in control of their body and we should therefore question if any decision made in this state can be considered autonomous. Trust is a significant aspect of autonomy. In order for the physician to trust decisions made by the patient in this time, they should be free of duress, and unnecessary harm. Vice versa from the patient's point of view, restraint communicates to the patient, the physician has little respect for their life or that of the newborn, reinforcing a feeling of mistrust between the two. Autonomy not only concerns decision making and privacy, but also the manner in which a patient is viewed and treated (Beauchamp and Childress, 2013).

Furthermore, lack of consistency among inmate restraint and favoritism amongst staff was also reported among patients.

Here, two violations of patient autonomy should be noted: violation of privacy and their physical circumstance while in a vulnerable state. The Health Information Portability and Accountability Act of 1995 allows involvement of those active in the care of a patient. In this case, this does not include the prison guard. Thus, one would conclude, guards pose a direct threat to the patient's confidentiality. However, although not explicitly stated, prisons do not honor the constitutional right of privacy of prisoners.

Pregnant inmates, as patients, deserve ethical treatment that safeguards their medical experiences and maintains their dignity as humans. The animalistic restraint and presence of guards during labor seems to be cruel and unusual.

Postpartum & Separation

Following delivery, labor support is allowed thirty minutes to remain with the mother. Typically, mother's that endure vaginal delivery remain with the child for twenty-four hours. For mothers having cesarean delivery, the newborn may stay with the mothers from forty-eight to seventy-two hours post-delivery (Fritz &Whiteacre, 2016). In reports, prison staff failed to disclose when and where newborns were relocated to (whether with the father, a family member or the state) aiding in distrust.

Following separation, some women choose to still breastfeed. Standard prison policy does not allow for direct contact with the infant. Mothers are given the option to pump electronically and mail breastmilk. The pumps and storage containers are to be purchased by the mothers. Per Fritz and Whiteacre (2016), breastfeeding is avoided, in part, due to the emotional distress emphasized by the separation, lack of finance and, predominantly, the mistrust of prison staff handling the milk.

For the incarcerated patient, lack of control summarizes the postpartum stage of prison healthcare. Muddied social dynamics between prison staff, physicians and patients continue to influence patient

decision making. Thus, ethicists have a duty to confront these challenges, in order to protect the standard of care owed to incarcerated prenatal patients.

IV. The Possible Longterm Effects of Imprisonment on Minority Populations

The current practices of prisons regarding the reproductive rights of patients are a reflection of their status as not fully citizen. Inmates have certain constitutional rights, typically the first and eighth amendments, but the majority of their protections fall under a separate section of specialized rights that chiefly protect against inmate to inmate violence, however, it is the systemic violence which causes more harm.

The remainder of my research will focus on long term effects of current prison practices cause to pregnant women, particularly speaking to Black and Brown women and their children. I plan to further discuss the ethicality of prisons adopting their own version of rights and where the government draws the line on what constitutes a citizen. In understanding the ethics of humanity as it concerns healthcare, we should question, which is more important: a prisoner's status as a person or a citizen?