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Commentary

All Restrained Patients Are Not the Same

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Abstract

This commentary offers a critique of the public health approach to hospital restraints proposed by Coyne and McDougall. While acknowledging the merits of their model, specifically its emphasis on protecting third parties, this commentary emphasizes that an ethical assessment of restraint is too complex to be situated on a single-axis continuum. Rather, a multidimensional approach is required that includes specific vulnerabilities of particular patients, the precise nature of the restraints being used, and the duration of their implementation.

Keywords: restraints; autonomy; medical ethics; physical restraints; chemical restraints

The ongoing debate over the use of restraints on hospitalized patients reflects an underlying tension between the moral imperative to minimize coercion and the clinical reality that restrictive measures are sometimes necessary to protect patients and caregivers from harm.[1] By reframing the use of patient restraints as occurring on a continuum between therapeutic interventions and public-safety measures, Coyne and McDougall have challenged the adequacy of existing ethical frameworks governing coercion in medicine.[2] They do so in two distinct but related ways. First, they argue that the two dominant lenses through which the issue is currently viewed, principlism and human rights, both overemphasize the interests of the individual patient. Second, they contend that these frameworks err in conceiving of restraint as a unitary phenomenon rather than one that exists on a spectrum between therapeutic purposes and those designed to protect third parties. Such an analysis is unquestionably a major step forward in that it transcends abstract principles in favor of applications that can be operationalized by providers in clinical settings. At the same time, by placing primary emphasis on the number of individuals affected by restraint, their approach loses sight of the other dimensions that shape the ethical assessment of restraint use: namely, the characteristics of individual patients, the distinct ways in which various forms of restraint impact those patients, and the significance of restraint duration for patient well-being.

Each patient carries a unique lived experience into a clinical encounter.[3] Optimal care requires, in addition to addressing diagnostic conditions, adjusting treatment to meet the specific emotional and psychological traits of an individual human being.[4] Treatment only works, after all, if the patient is willing and able to adhere to it. Differences in personal history and psychological vulnerability are no less relevant when deciding whether, and how, to restrain a patient. For instance, placing restraints on a survivor of severe abuse or sexual assault can prove retraumatizing.[5] Similarly, an individual with a previous history of incarceration, and especially mistreatment in a carceral setting, may be especially sensitive to experiences that evoke memories of prior coercion or victimization.[6] Physicians routinely take such lived experiences into account when deciding whether to impose restraints. The cognitive state of the patient may also matter. A patient who is alert and lucid will not only undergo the immediate stress of losing autonomy, but may also endure distress in the future when thinking back upon the experience. In the extreme, such patients might even be at risk for post-traumatic stress disorder (PTSD).[7] In contrast to trauma survivors, some patients who are intoxicated or floridly psychotic report little or no memory of the event, although others do recall the event after the restraints have been removed.[8] Evaluating the choice to restrain in the context of the distinctive traits of the patient — especially the degree to which they will likely suffer at present and in the future from the experience — is crucial to any ethical assessment. By shifting attention away from the individual patient, Coyne and McDougall's one-axis continuum approach risks obscuring the fact that the ethical significance of restraint depends not only on whom it protects, but also on whom it restrains. To channel William Osler, it may be much more important to know what sort of patient one is restraining than why one is imposing restraints.

Coyne and McDougall note that restraints may take physical, chemical or mechanical forms. Yet their framework leaves insufficient room to account for the morally significant differences among methods of restraint. In addition, the impact of a given form of restraint may vary considerably depending on a patient's lived experiences. For instance, patients with a significant history of severe mental illness such as schizophrenia who present with psychosis to an emergency department may find a sedating injection of haloperidol to be a comparatively minor intrusion, even though the injection occurs against their will and overrides autonomy. A highly intoxicated patient receiving a cocktail of haloperidol and lorazepam under similar circumstances may not even recall the experience when sober. In contrast, placing those same patients in four-point leather restraints may prove deeply upsetting. Conversely, forcing an injection upon a medication-naïve patient in order to then administer medically needed treatment may cause

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profound distress. For some complex trauma patients, being physically restrained by a security officer, even briefly, may be far more objectionable than either chemical or mechanical restraint. Moreover, one form of restraint is frequently imposed to prevent the need for another form of restraint that may be far more harmful to a particular patient.[9] For instance, a low threshold for chemical restraints may be ethically indicated when the effect of physical or mechanical restraints on a particular patient risks grave psychological harm. Sacrificing some autonomy in such cases may be well justified in the spirit of nonmaleficence if the potential harm of the form of restraint being prevented is great enough.

A third aspect of restraints not adequately addressed by the Coyne and McDougall paradigm is their duration. Duration is not merely a quantitative difference. A restraint maintained for hours or days may impose psychological and dignitary harms that are qualitatively different from those associated with a brief intervention undertaken during an acute emergency. The length of restraint in the hospital setting can vary drastically, ranging from a brief physical hold to administering a life-preserving medication to patients kept in soft restraints for days to prevent them from pulling out IVs.[10] For some patients, any loss of autonomy may prove a source of distress. In contrast, for others, the impact of a brief physical hold may prove minor when compared to lengthy restrictions on liberty. When making an ethical assessment of the choice to restrain, the duration for which restraint is likely to be necessary to achieve its intended purpose may be an important consideration. Furthermore, the ethical significance of duration may vary depending on both the form of restraint employed and the characteristics of the individual restrained.

Coyne and McDougall are correct that "current definitions do not incorporate all ethically relevant features of restraint in hospital settings."[11] By emphasizing the public health nature of restraints, they have contributed an important element to conversations around the ethics of restraint that until recently have largely emphasized human rights and principlism. The continuum proposed by Coyne and McDougall identifies one ethically important dimension of restraint, but it should be supplemented rather than treated as exhaustive. Needless to say, introducing additional dimensions risks reducing the practical utility of the Coyne and McDougall framework. After all, a compelling virtue of a one-axis continuum is simplicity. However, the ethical issues raised by restraints in the clinical setting are too complex to be analyzed one-dimensionally. Rather, ethical evaluation may require at least four dimensions: number of persons affected, individual patient vulnerability, mechanism of restraint, and duration of restraint. The decision to restrain a patient must occur in the context of a full analysis of the particular circumstances, including the patient's specific attributes and how that patient in particular will be affected by the nature and duration of the proposed restraints. Additional factors might also prove relevant in some circumstances, such as particular attributes of the third parties being protected from the patient. Coyne and McDougall have offered a valuable first step toward reshaping attitudes toward this complex moral subject, but ultimately a more sophisticated framework that incorporates all of these variables, and possibly others, will be necessary to facilitate ethical decision-making by physicians in clinical practice. Any framework designed to guide ethical decision-making regarding restraint must account not only for whom restraint protects, but also for whom it restrains, how it is imposed, and for how long.

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