Restraints and the code of ethics: An uneasy fit

Wanda K. Mohr

This article examines the use of physical restraints through the four broad principles of ethics common to all helping professions. It asks whether the continued use of physical restraints is consistent with ethical practice through the lens of those principles. It also examines where the necessity to use restraints in the absence of empirically supported alternatives leaves professionals in terms of conflicts between ethical principles and makes recommendations for changes in education and clinical practice. It concludes that an analysis through a bioethics lens demonstrates that the use of restraints as a tool in psychiatric settings is a complex and multifaceted problem. Principles of ethics may often be in conflict with each other in instances where patients must be physically restrained.

THE UNFORTUNATE NECESSITY of physical restraint is a part of professional nursing that nurses often find troubling. Nurses report that they prefer to use other means to manage aggressive behavior, that they are not altogether comfortable with restraint use, and that the process is as painful for them as for their patients (McCain & Kornegay, 2005; Bigwood & Crowe, 2008). Yet, there are times when physical restraint is the only possible course of action open to caregivers, and holding or tying a patient down is a better alternative than allowing patients to injure themselves or compromise others' safety. Knowing that restraint use may be dangerous and traumatic, however, puts thoughtful practitioners in a clinical quandary. An example of a situation where restraint is unavoidable might be that of a delirious patient who becomes violent and threatening to bite and hit staff members or to hurt themselves with whatever weapon is available. Surely, staff members are morally obligated to keep this person from being a risk to themselves and other patients despite putting the restrained individual at risk from the restraint itself.

There is little question that physical restraint of a patient is a coercive and risky procedure that has been abused and misused (U.S. General Accounting Office, 1999). Deaths have occurred because of improper restraint use (Wendkos, 1980). On May 26, 2006, 7-year-old Angellika Arndt became a casualty of physical restraint. Angellika was in a Wisconsin day treatment program and had been restrained nine times in 4 weeks. She was restrained by staff members in a prone, face-down position for up to 2 hours during each episode. The medical examiner ruled her death a homicide due to "complications from chest compression asphyxiation" (Reynolds, 2006).

The same events have happened with depressing regularity in facilities that exist to provide therapeutics and mental health services to children and youth. Nunno, Holden, and Tollar (2006) examined a number of nonmedical databases and determined that, between 1993 and 2003, 45 child deaths had been reported. Such occurrences are a reality in mental health settings (Fidone, 1988). It is not known how many or how often they happen as some deaths occur in facilities that are not obliged

From the Psychiatric Mental Health Nursing, UMDNJ School of Nursing, Stratford, NJ.
Corresponding Author: Wanda K. Mohr, PhD, APRN, FAAN, Psychiatric Mental Health Nursing, UMDNJ School of Nursing, Stratford, NJ 07107-3001.
E–mail address: mohrwk@umdnj.edu

0883-9417/1801-0005$34.00/0
doi:10.1016/j.apnu.2009.03.003

to report them to accrediting or regulatory agencies, and there is no centralized data collection system to track these deaths.

Mental health services are provided by a myriad of different helping professionals, both within and outside of institutional settings that include physicians, social workers, nurses, psychologists, and adjunctive therapists. All have a code of professional ethics. These codes are public statements that set clear expectations to guide practice, speak to the core values of the profession, and form the basis of a trustworthy relationship with patients. The codes are more similar than dissimilar and, although there are other principles to be considered in the field of ethics, the professional codes of ethics are broadly based on the principles of beneficence, nonmaleficence, autonomy, and justice. The codes derived from the aforementioned set of principles are meant to be applied to the individual exercise of professional judgment. These principles are particularly germane in mental health as psychiatric patients are a particularly vulnerable class. Psychiatric illnesses can affect the individual's cognitive, behavioral, emotional, and social functioning; their impact may compromise patients' ability to fully participate with the treatment team in their care. Equally important, organizational realities and ecological factors (Zimbardo, 2007) raise concerns as to the pressures that health team members face and how these factors can seriously impact ethical practice.

Patients and their families trust that professionals will practice competently and ethically. Trust is a vital component of and a basis for relationships between clinicians and patients. These interpersonal trust relationships have moral content—fidelity to trust is morally praiseworthy; betrayal of trust is morally blameworthy. The need for trust and reliance on trust are especially important in health care because of patients' acute vulnerability to suffering, lost opportunity, and lack of power (Goold, 2001). Insofar as patients under professional care in mental health facilities die because of that care begs that we not only examine that care but also ask whether the restraint use is consistent with the spirit of the principles set forth in professionals' codes of ethics.

This article considers the principles underpinning the ethical codes of the helping professions and examines whether the continued use of physical restraints as a clinical tool in our treatment armamentarium has fidelity to those principles. The four bioethical principles common to most codes of ethics are discussed as they relate to the use of physical restraint and how the use of this coercive practice has the potential to violate each of those principles. This article also recognizes the tension among conflicting responsibilities when maintaining safety becomes a paramount and how principles can come into conflict. The discussion is limited to psychiatric and residential treatment settings that serve adult and child–adolescent populations. Recommendations for changes in education and practice are made, and identification of best practice model and research is called for.

PHYSICAL RESTRAINTS

As employed in psychiatric settings, physical restraint is a security measure designed to protect patients and staff in instances where safety may be compromised. The justification used for their use is if patients are a clear danger to themselves or others in their environment. Restraints are sometimes necessary, but they have been misused and overused (U.S. General Accountability Office, 1998). Definitions of *restraint* range widely, but broadly the term refers to physically restricting movement. Mechanical restraints are leather or cloth devices, bedrails, or geri-chairs used to modify the behavior of an individual through the limitation of physical movement. In the United States, mechanical restraints are rarely applied in psychiatric inpatient or in residential treatment facilities but may be applied often in medical–surgical settings and long-care settings providing care for geriatric populations (Moss & La Puma, 1991). Indeed, in some countries, the use of mechanical restraint in psychiatry is seen as unethical (Gordon, Hindley, Marsden, & Shivayogi, 1999; Moss & La Puma, 1991).

Generally, physical restraints in the case of larger patients consist of their being held by several people on the floor in a supine or prone position. Smaller, younger patients are held papoose style in a "basket hold" or in what is euphemistically called a *therapeutic hold* (Child Welfare League of America [CWLA], 2004).

AUTONOMY

At the core of western morality is the basic belief in individual freedom. Respect for autonomy is a reflection of this morality and, in the United States, is based on the right to privacy and self-determination. Two fundamental components of autonomy are *liberty*, the right to self-determination without