

Restraint Use and Autonomy in Psychiatric Care

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ABSTRACT

The use of four-point physical restraints has long been controversial in psychiatry. But the most common objections against these restraints hinges on the idea that they would be imposed against patients. In light of the trend towards giving patients access to Advance Directives, why not allow patients to use such legal documents to arrange for restraints being used against them? Patients might do this if they feared an inability to make competent decisions in the future. Proper oversight over the requests and the restraint-use would help psychiatric patients plan for their own care. Clearly, not all patients would qualify for such an expansion of their autonomy. Many would be unable to give adequately informed consent. Still, for the patients who could consent, being able to draw up such a "Ulysses Contract" could provide an improved balance of risks and benefits.

Of the means of physically controlling patients in psychiatric institutions, the most controversial is the 4-point restraint (4PR). Use of the 4PR involves a patient being "placed on a bed, which is bolted to the floor, and both of his/her ankles and wrists are secured in leather restraints. Two additional leather straps are [then] placed over the patient's legs and chest" (Schreiner, Crofton and Sevin, 2004, p. 451). From advocates for patient rights to scholars on healthcare law, virtually everyone seems to agree that the less 4PRs are used, the better (Sullivan, et al., 2005).

This strong stand against the 4PR derives primarily from the reasonable belief that "being treated involuntarily in psychiatric care" is a threat to "the integrity of the patient," and that this way of treating patients is among the worst (Johansson and Lundman, 2002, p. 646). Critics also cite the dark history of restraint use in psychiatry and the fact that in industrialized nations the rules governing the use of physical restraints are becoming stricter (Grob, 1994). In some European countries the use of 4PRs is almost unheard of (Fairman and Happ, 1998). Mindful of these trends, critics urge an end to the use of 4PRs (Tumeinski, 2005; Weiner, Tabak and Bergman, 2003).

A possibility rarely considered, however, is that a patient might arrange for the restraints to be used. Such arrangements would be in keeping with the general move towards giving patients more

say in the risks that they take. There are already provisions for Advance Directives (ADs) in psychiatry, as there are in medicine overall (Brock, 1993; Matthews, 2000; and VanWillingenburg, 2005). These contracts give patients in a psychiatric institution greater control over their own therapy, mainly by spelling out legal arrangements that are to take effect if the patients become unable to make competent decisions. Although the usage of the AD is more common in emergency medicine, the documents could be designed around the idea that a psychiatric patient might not be able to adequately communicate his or her preferences regarding the 4PR.

Humiliation and Autonomy

The main objection against this would be paternalistic, that the 4PR is beyond the pale, and that institutions have an obligation to prevent patients from choosing something that will lead to their own humiliation and possible mistreatment. According to one critic, the "most important point . . . is that tying someone spread-eagled to a bed is very degrading" (Saks, 2002, p. 162). In Saks' opinion, "it is hard to imagine a more humiliating intervention" than the 4PR. For this reason, Saks would allow patients to ask for a helmet "in a padded cell" if they posed a threat to themselves, but insists that a request for "more drastic forms of mechanical restraint should never be honored" (Saks, p. 162).

Objections of this sort are flawed, inasmuch as they simply declare the 4PR humiliating and then move to the claim that patients should not be allowed to request it. Such reasoning can easily take a logical shortcut and gloss over several important points. First, there are varieties of paternalism, with some interventions on behalf of the patient being more easily defended than others. Second, there is no clear, agreed-upon account of humiliation or the moral relevance that the potential for humiliation should have. Taken together, these points suggest that any proposal for the AD must show that these legal arrangements will cater to the interests of the patients and that the imposition will be consistent with limitations that the patient him or herself can accept while able to give consent in advance.

This way of establishing the groundwork for the proposal concedes that there are very real risks associated with the 4PR, including the heavy psychological and emotional costs to everyone involved with the restraining process (Singh, et al., 1999). There are also physical risks that would be present any time someone is forced into the restraints. But whatever else humiliation is, it seems to

be a cluster of reactions that we can only gauge from reports or statements that the person being humiliated might give. This means that humiliation might be what the affected person says it is, rather than what an observer would predict. It also means that we should be skeptical of second-hand predictions of what patients might or might not experience.

Where our primary basis for narrowing the range of patient choice is a state of humiliation that we presume that the patients will experience, our restriction looks arbitrary. Some patients might find restraints of any kind humiliating, just as many will have strong reservations against the 4PR. But this may not tell us much, since, as the 4PR is one of the most extreme forms of restraint used in institutional settings, it is understandable that some patients might have very negative opinions about its use.

As tempting as it might be to think that one patient at risk of humiliation is one patient too many, a large slice of human experience is concerned with our trying to adjust our response to situations or outcomes that we believe might lead to some type of humiliation. In these instances, humiliation or fear is not always sufficient reason to avoid the situation entirely. Medical care involves routine trade-offs between benefit and potential embarrassment. Visits to the clinic can involve catheters, bedpans, frank discussions about bodily secretions, nakedness in front of strangers and so on. An urologist's patient can consent to having a nurse hold his penis while the urologist pushes a flexible microscope through the patient's urethra with technicians, medical students and others possibly looking on. It is odd to not let that patient also consent to a possible 4PR out of concern over embarrassment.

The best course would be to determine if the 4PR offers an acceptable balance of risks and benefits for patients who would draw up the AD and, in some cases, for those with the status of substitute decision-maker. The patients who qualify for the AD will hardly look forward to being restrained; the intent of the proposal is not to "sell" patients on the virtues of being strapped to a bed. Rather, the point is to allow a mechanism for certain patients that will let them derive some value from their increased ability to take an active role in determining when and how this treatment will come about.

This needn't amount to a system whereby the patient would invite humiliation. An assumption at the core of the proposal is that there will be an absence of malice or the other harmful intentions that we ordinarily associate with something like humiliation. The premise behind questions about whether patients ought to be able to negotiate for a period of humiliation are thus difficult to accept. Humiliation may well occur, but that outcome would not have to represent a lack of social skills or moral competency in the patients. Even if reform of personal character is accepted as one of the goals of psychiatry, limiting the responsibility that patients can take for their own care seems a poor way to achieve it. Proper oversight could ensure that patients arrange for a 4PR only when this will help restore a sense of dignity, self-control, and self-respect.

Informed Consent

There are legitimate concerns about whether, given a possibly diminished emotional and cognitive state, patients rationally mull over the request for a 4PR. A similar objection is often made to

allowing prisoners to consent to medical research. The presumption is that they would be all too willing to accept treatment that non-prisoners would find abhorrent. Might the AD prove to be an "offer" that some patients would not be able to refuse? (Slomka, et al., 1998).

Fortunately, medical institutions are used to dealing with moral quandaries about access to treatment. Because of wide variation in decision-making capacity, the 4PR would clearly not be appropriate for every patient. Some patients might present inadequate reasons for wanting to be restrained, for instance. But it would be wrong to therefore deny all patients access to an AD out of concern for such possibilities. The more promising course would be to treat the decision to contract for the 4PR as we would any other that the patient might make, or that a patient might make in conjunction with proxies and substitute decision-makers.

To this end, one commentator tells of a patient who would insist on receiving the liquid medications that he saw other patients receiving; staff responded to this behavior by giving the patient "fruit punch whenever the others were receiving their supplements" (Donat, 2005, p. 1106). Granting the differences between the types of treatment and recognizing that the presumption would be against associating deception with the 4PR, the point is that staff can find ways around inappropriate patient requests. There is no justification for arranging to subdue a patient because he or she desires physical contact, for instance, and oversight committees can assess these and others reasons that patients might give for wanting the 4PR. They committee members can do this, that is, just as they assess other aspects of the patients' care.

The idea behind the AD is that "one clear advantage to respecting autonomy is that people tend to know best their own value structure, for example, what they are willing to endure, and generally have a good sense of the basis of their own well being" (DeMarco, 2002, p. 241). But the paternalist might allege that consenting to the AD requires patients making judgments about their future well-being in a way that many would be incapable of doing. The patients can, after all, misjudge their own thresholds of embarrassment or discomfort, and there is some question of which patient we would restrain, the one who requests the AD one week, or the one who fights against it a week later (Olsen, 2003).

Shortcomings in human judgment, along with ambiguities over moral personhood, do bear on the ethical question. Under consideration are "Ulysses Contracts," which will stipulate the restraints to be provided, and will tell staff to ignore the patient's opposition to that treatment. The common usage of the term "Ulysses" in this context can be a bit misleading. The general idea is based on the idea that Ulysses asked his men to restrain him, aware that he would at a future time tell them to do otherwise. As a specialized form of the AD, a Ulysses Contract would, in effect, tell the staff to disregard any objections the patient makes in the future, when certain conditions exist.

As unconventional as this might sound, there is nothing mysterious about the possibility that patients will change their minds or that they might want someone to over-rule their later decisions. Patients who opt for the AD expect to change their minds, otherwise they would not be requesting that the staff ignore their protests later. This suggests that, if anything, we should puzzle over patients who

arrange for the AD and do not find the restraints offensive. Such a patient would likely not need restraining.

The sort of uncertainty in contention here is a feature of any request that the patient might make. There is no reason to rule out the Ulysses Contract when we do allow patients to make similar judgments that project their interests into the future, as they would with the AD. Philosophical quandaries like these reinforce the notion that such a contract would not be appropriate for all patients (Miller, 1998). Advocacy of the Ulysses Contract needn't side-step these quandaries; all should recognize that the case for these arrangements will inherit all of the moral uncertainty typically linked to the use of an AD. Indeed, one of the reasons that the AD might not enjoy wide application is that the freedom to choose, and the understanding of the choices, would have very different significance for each patient (Kukla, 2005; Thomas and Cahill, 2004). But this fact only reinforces the need to ensure that patients understand the dimension of choice that they would be gaining and relinquishing, to be eligible for the AD.

A related criticism would hold that the situation in the psychiatric institute might be grave enough that some patients could consent to things that they would not outside of that setting. But this is a misleading objection. Procedures like the 4PR have little use to anyone who was not in such a setting to begin with, so it is difficult to compare the selection of the AD with a choice that one might make in another context. Perhaps the real issue is whether the influences on the patient's decision-making would be so great as to amount to coercion. That matter is best settled with empirical evidence and individual counseling, however.

The mere possibility of strong influences on the patient's thinking should not invalidate decisions about the Contract. Guidelines can give patients the benefit of the doubt to decide against certain medical treatments, like chemotherapy, if they feel that the risks outweigh the benefits. Patients retain this right, even when their refusal can be expected to hasten death, and with doubts concerning the influences on their decisions. Laws that allow adult patients to refuse necessary blood transfusions illustrate this same dimension of autonomy. These points force the paternalist to show why it is acceptable in some cases to respect a choice that will almost certainly lead to a patient's death, without assuming that influence equals coercion, yet deny that same patient the ability to sign a 4PR directive.

Again, no one should pretend that consent will eliminate ambiguity in this context any more than it can in others. It is certainly true that consent will not preclude some patients from getting themselves into situations radically different from what is expected or needed. The argument here is only that consent would be a step towards meeting the patient's needs, and the prospect of misjudgment has to be set against the positive features of the AD. Not the least of those advantages is the fact that the restraints would be temporary and, unlike other procedures, the 4PR would not pose a risk of lasting emotional or physical harm.

The 4PR As Medical Treatment

Critics (e.g., Tannsjö, 2004) might question how detailed clinicians

could be when giving eligible patients an account of the risks and benefits. Reliable data on the 4PR is scarce, some allege, making the act of subduing patients "experimental" medicine, not standard care (Moss and La Puma, 1991). Others add that there is currently insufficient evidence about the effectiveness of ADs of any kind in psychiatry (e.g., Varekamp, 2004).

One could reply, however, that this too is an empirical question. Why not tentatively introduce the ADs, and examine the role that this and other Ulysses Contracts might play in psychiatry? Institutional guidelines now let patients participate in clinical research. Patients can now consent to similar research, or they can consent by way of family members and proxies. Significantly, some experimental treatments pose long-term health risks, which the 4PR would not. We can look on the restraints as experimental and simply devise protocols around the 4PR with all of the safeguards that such a categorization usually involves.

In other words, treating the restraint procedure as research would only be a good thing if this adds a layer of oversight. Rules could allow for patients to consent only when they can show that they understand the comparative lack of clinical evidence for the efficacy of the restraints. Guidelines could give patients, family members and others a way to monitor the choices that the patient would be making if this was deemed necessary.

Increasing our knowledge of the effectiveness of the AD could also clarify the role that it plays in the patient's care. There are many ways to describe or defend something done to or for the patient, depending on the particular orientation towards therapy. It might be true that the color of the paint in the patient's room is to some extent part of the type or quality of care, but this is not the same as saying that wall color is itself medical treatment. Institutional guidelines for the AD might help clarify the distinctions between a purported therapeutic use of the restraints, as something to directly benefit the patient, and a use of the restraints in therapy, as something useful for facilitating other aspects of their care.

Would Consent be a Hollow Gesture?

In the end, might the AD seem like a redundant legal device? Institutional regulations could already permit staff to impose whatever restraint is necessary to maintain control over patients who pose immediate threats to themselves or others. This could make obtaining a signed Contract look like a pointless ritual, in light of what is bound to happen regardless of how the patient decides. A critic might add that the goal should be the elimination of the restraints, not a facade of consent for them.

The concern in this objection is important, but misplaced. If the 4PR will be used regardless of what some patients want, this supports giving them a greater sense of control over how the restraints are used. A measured approach to using the Ulysses Contract could offer real benefits to patients, families and staff. This would not continue the legacy of mistreating patients with the restraints. Both patient and provider would have to understand the importance of managing aggressive or disruptive behavior, ideally without restraints, in order for the potential use of the 4PR to be justified.

Where there are gaps in the communication of this nature, and where oversight leaves room for workplace sadism, the institution is facing a problem with its personnel, not an inherent defect in the use of the 4PR. Mandatory monitoring of the restraining process, along with documentation and additional training, could go hand-in-hand with a level of choice that would not be merely symbolic. Any informed consent procedure has its ritualistic qualities, but far from being a strike against the proposal for the AD, this serves as one reason why patients are better off with such routines. The symbolic leveling of authority and privilege enhances the moral significance of the compromise that doctor and patient can make about interests and resources.

Giving patients this power of consent would, in addition, not have to be part of an attempt to bring the restraints into the ethical mainstream. There are good reasons to work towards a system of care that involves the least invasive form of restraints possible, if only because of the dark history of restraint use. If critics are right, however, some degree of reform is in the interim warranted. Not only that, the potential for patients and their advocates to take part in dialogue about how and when the AD should be implemented would mark a positive turn in the history of psychiatric care. Finally, barring access to Ulysses Contracts will not resolve problems related to the possibility that the 4PR will be used whether patients give prior approval or not.

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