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Physical restraints: ethical and legal argumentation

Review

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Abstract: Physical restraint is one of the most controversial methods in managing aggressive behaviors and maintaining patients' safety. This manuscript purposed to convince stockholders and policymakers of the negative impact of physical restraint on patients' psychological and physical health. The current authors review the ethical and legal underpinnings of the opponents' and proponents' views. On one hand, there is a clear violation of the main principles of the code of ethics. Autonomy and justice; as the patients are tied against their will and without obtaining their consent, non-maleficent; as physical restraints are reported in many cases of physical and psychological traumas, thus many agencies prohibited the use of physical restraints as a safety method to be replaced with other de-escalating techniques. On the other hand, physical restraints are a precious method in controlling aggressive behaviors and maintaining patients' safety, which is the selective beneficence in providing patient care. Also, most of the same agencies who prohibited the use of restraints, agreed the use of physical restraint as the last resort.

Summary statement
What is already known about this topic?

- Currently, physical restraint is used as the first accessible method to manage patients' behaviors, without considering the negative aura that surrounds the way of treatment. The usage of physical restraint has gone beyond the purpose of maintaining patient safety and managing aggressive behaviors to be a punishment method.
- The Ethical and Legal context of using physical restraints is still vague and needs more clarification.

What does this paper add?

- This manuscript illustrates the Ethical and Legal points of view of the opponents and proponents of using physical restraints.
- The current manuscript clearly justifies the authors' point of view to oppose physical restraints usage and how physical restraints violate the core principles of the code of ethics. In addition, it illustrates the legal agencies that support/oppose the usage of physical restraint and the rationale beyond that position.
- This manuscript provides alternatives to manage patients' aggressive behaviors and other ways to protect patients' safety as well as patient's dignity and code of ethics.

The implications of this paper

This argumentative essay provides an accessible, relevant exploration of public health policy, and its impact on nursing practice, mental health services, and patient health. Moreover, it provides a forum for mental health services to evaluate the current implications of physical restraints. The manuscript creates a paradigm for future studies and projects on physical restraints usage.

Keywords: *argumentation • ethical • Jordan • legal • physical • restraint*

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1. Introduction

The philosophy of patient care is based on the concept of respect and response to all patient needs and values, and ensures that patients guide all their clinical decisions. “Patients’ safety” is a “non-negotiable part in the delivery of quality healthcare.”[1] Nurses are considered the primary healthcare providers who take the responsibility to ensure the quality and safety of patient care.[1] However, what if this care invades patient values, needs, and dignity? What if this care provides more harm than benefits? What if this care provides more problems than it solves?

Physical restraints are defined as physical devices, materials, or equipment connected to the resident’s body that cannot be removed easily which results in restricting individuals’ movement and freedom or normal access to their own body, devices ranging from belts and limb tie devices to a specialized product like chairs and beds.[2] The use of physical restraints in psychiatric settings started from the beginning of psychiatry, *which was designed to handle violent and destructive behaviors, reduce agitation, and prevent injury, as well as manage patients with severe mental disorders*.[3] Worldwide, the prevalence of physical restraints ranged from 5% to 17%. In the United States only, the incidence rates of mechanical restraints increased from 29% in 2007 to 34% in 2013.[4,5] *Given the fact that* 80% of ICU patients experienced agitation, delirium, and confusion during their hospital stay, restraints are widely used in medical settings, especially in acute care settings,[6] those patients attempt to remove their invasive procedures, which jeopardizing them to the risk of death. Hence, restraints are used to promote the patients’ safety and quality of care.[7] This intervention can be effective if used as the last resort in maintaining the patients’ safety and preventing injuries.

On the other hand, physical restraints are considered a traumatizing method and invade the principles of patient care and patient dignity. *This controlling intervention is associated with many unpleasant complications for the patients and their family members, either physically like* decubitus ulcers*,* bruises, undernutrition, impaired muscle strength, paradoxical agitation, and death or psychological distress.[8,9] However, physical restraints are still one of the challenging questions in medical and psychiatric services, and are always considered as an ethical and legal argument. Therefore, the purpose of this argumentative essay is to articulate the opponents’ and proponents’ views regarding physical restraints from ethical and legal perspectives.

The authors of this paper are completely opponents of using physical restraints, as illustrated from the literature that it may cause much physical and psychological harm to the patients and their family members, and is markedly invading patients’ dignity, autonomy, principles of treatment, and quality of patient care. In some cases, physical restraints may fail to achieve their intended goal of ensuring patient safety and reducing agitation; instead, they can escalate agitated behaviors and cause more harm than expected. Despite all these disadvantages, the authors of this paper support applying physical restraints only as the last choice in maintaining a patient’s safety.

2. Physical restrain

2.1. Ethical opponents

Physical restraints are designed to maintain the patients’ safety and prevent harm. In the ethical context, physical restraints violate a patient’s dignity, self-determination, and the code of ethics principles.[10] Autonomy stands for the ability of individuals to make decisions about their values; in looking at the components of autonomy, liberty is the right of self-determination without any control or coercive manipulation. Agencies are in the full capacity to make decisions and act intentionally. Undoubtedly, physical restraints break the core meaning of autonomy and its components when patients are tied against their will and when they do not have the power to accept or refuse any decision even about their health, which leads us to the paternalistic way of treatment.[11] In the context of paternalism, an injustice issue emerges when the staff, who are working in the psychiatric settings, have the power over all their patients’ activities of daily living, which induces those powerless patients to live like flocks without any decision. As evidence, in Northern Ireland, a longitudinal observational study was conducted on hundred two patients, showing that restrained patients were more dependent on nurses in doing their self-care and expressed lower self-determination than patients who were never restrained.[12] That culture of treatment will provoke a sense of persecution and might convert the staff to tyrants rather than professional healthcare professionals.[10] Upon that understanding, using physical restraints will go beyond the purpose of protecting our patients to be a way of punishment and behavior manipulative method rather than a safety technique. Inevitably, it will destroy the nurse–patient relationship, which must be protected under any circumstances.[13] So, are physical restraints considered as a part of physical punishment?

Physical punishment is aimed at reducing unpleasant behaviors of the individual by using non-injurious

materials to contact the individual. Physical punishment could provoke a sympathetic nervous system that initiates the fight-and-flight response to being protected from the one who is trying to punish.[13] In 2009, a study conducted to understand patients' impression of using physical restraints by health care providers, most of them frankly described it as a "cage" and they perceived it as a clear punishment for their unpleasant behaviors.[12] Physical restraints result in physical and psychological injuries including skin injury, pulmonary disease, nervous system damage, deep vein thrombosis, and death. Also, coercive tendon immobilization might cause tendon and muscle damage or tear, as well as functional disability, which can lead to an extended hospital stay and failure to discharge. Psychologically, it may result in fear, anger, elevated stress levels, demoralization, loss of self-respect, social withdrawal, depression, and even psychosis.[14,15] When reflecting on the meaning of beneficence, act with benefits and non-maleficence, no harm, we found that it is inconsistent and opposes the deep meaning of the two concepts.

2.2. Legal opponents

Human Rights Article 3 states that no one shall be subjected to torture or inhuman or degrading treatment or punishment. Serious physical and psychological abuse in health care settings and threatening to torture someone is inhumane treatment and purely violates the Human Rights Act. Whether inhuman treatment or punishment is degrading and subjective; it is enough for the patient to feel humiliated and debased, even if it was non-intentional or for protection.[16] The National Mental Health Consumer & Carer Forum (NMHCCF) revealed that physical restraints are not evidence-based practice and are considered an avoidable and preventable practice that should not be used in Australian mental health services.[17]

In the '90s, the Hartford Courant released a group of articles that discussed many adult and child death cases because of improper restraint usage in mental health facilities with 142 deaths across the country distributed between 1988 and 1998. Besides, the court retained researchers from the Center for Risk Analysis at Harvard's School of Public Health, who released shocking estimated rates of improper restraint usage deaths to be between 50 and 150 deaths every year.[18]

Depending on the courant's publication, Connecticut's Congressional delegation released a set of legislation that regulates the use of dangerous interventions. Followed by reducing and prohibiting regulations of restraints usage by other different agencies, the American Psychiatric Association (APA), the National Association of Psychiatric Health Systems (NAPHS), the American Hospital Association (AHA), the National Mental Health Association (NMHA), and the American Psychiatric Nurses Association (APNA) provided that physical restraints are prohibited in general; patients shall not be restrained unless restraints are determined, should be consistent with the golden rule of using restraints as the last resort in preventing patients from injuring themselves or others when all other resorts are depleted, and should not be prolonged beyond the necessary time to accomplish that purpose.[19–21] Furthermore, the Washington Department of Social and Health Services reported that clients have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and which are not required to treat the client's medical symptoms.

2.3. Ethical proponents

There is no doubt that physical restraint is inconsistent with the principle of autonomy as patients are restrained against their will and without obtaining their permission in advance.[22] However, agitated patients with mental illness will refuse any means of medical intervention under any circumstances, not only being restrained. Given the fact that those patients are considered as a threat to themselves as well as others, consent forms are hard to conduct in such situations and patients. The Mental Health Commission (MHC) (2023) reported that interventions with explicit therapeutic goals may be conducted without consent and if we consider that physical restraint is a method to handle a patient's aggressive behaviors to protect the patient's safety and protect others, it could be applied without conducting consent. Indeed, only after the appropriate deescalated intervention, aggression would be alleviated, which is the implementation of measures to benefit patients. Specifically, the benefit of implementing physical restraint is selective intervention beneficence, which is designed to protect patients from injury.[23]

In terms of beneficence, it is defined as acting for the benefit of your patients, and non-maleficence means no harm. Upon that, the nurses who would work under both previous concrete concepts, should not do any intervention if they cannot warrant free-of-risk interventions, which is missing the logic that most of the caring interventions have part of the risk. Thus, balancing between the patients' safety and free-of-risk intervention is mandatory. In psychiatric settings, many types of destructive behaviors may emerge with high risks to the patients and others, such as aggression, suicide, and self-injury, where the implementation of physical restraints guarantees the interest of beneficence to most people and prevents the staff, the patient, and other patients from violence.[10] From the perspective of ethical context, we

concluded that there is a clear conflict between the principle of beneficence and autonomy.

2.4. Legal proponents

The Mental Capacity Act (MCA) (2005) authorizes the use of physical restraints if it is expected to prevent the patients from harm, while obviously, restraints meet that and are appropriate in preventing patients from harming themselves and others. Also, the South Eastern Sydney Illawarra Area Health Services (SESIH) emphasized the important role of physical restraints in assuring the patients' safety by developing a policy that regulates the use of physical restraints and considers using restraints as an inevitable way of managing agitation and self-destruction behaviors. However, the Mental Health Commission (2009) claimed that physical restraints should only be served when all other resorts are depleted. Medical staff must implement a medical review no later than 4 h after commencing bodily restraints and those patients should be assessed every 2 h for circulation and skin integrity. Patients who have experienced physical restraints must be closely monitored by professional practitioners as long as they are restrained and should be monitored for the benefits gained from being restrained and the changes in their condition to some extent.[23,24]

3. Argumentative statement

The use of physical restraints is not a new concept, but still, a controversial ethical dilemma and legal debate. Given the previous context in which the use of physical restraints was discussed in detail, comprehension and evaluation of both opponents' and proponents' views of the issue of interest, the authors of this paper are concordant with the opponents of physical restraints and against its usage, but to some extent, the authors support using physical restraints as the last resort in maintaining the patients' safety.

Ethically, physical restraints are purposed to prevent patients from other harm. However, in the ethical context, physical restraints emerged with a clear threat to the principles of the code of ethics; autonomy, justice, and beneficence. Given the fact that our patients in most cases do not consent to be restrained, they lose the right to act intentionally as well as the right to self-determination of treatment if it is considered a type of treatment rather than punishment. In addition, the beneficence principle of ethics is invaded by the physical harm reported in many cases of physical restraints which range from skin and tendon injuries to organ dysfunction.

Legally, most agencies direct their attention to the burden of using physical restraint and start to compare the benefits versus its harm, depending on that Connecticut's Congressional Delegation prohibited the use of physical restraint and set many rules to reduce the use of physical restraints. While the APA, NAPHS, AHA, NMHA, and APNA proposed that physical restraints are generally prohibited, they can be used as a last resort. Therefore, the following are recommendations that aimed to ensure and maintain the patient's safety.

4. Recommendations

- Educating the health care professionals about the nature, consequences, and possible side effects of physical restraints as well as educating them about patients' needs and how to satisfy these needs.
- Informing the health care professionals that it is completely not ethical to restrain the patients because they did not comply with the treatment. However, if physical restraint is to be used it should be the last resort and a consent form shall be signed by the patient or the kin.
- Assuring that once using physical restraints, it should not be later than 4 h and the nurse must assess the restrained patients every 2 h for inspection of circulation and skin integrity.
- Using technology (such as cameras, infrared, and sensors) instead of physical restraints maintains the patients' safety and prevents the unpleasant side effects of physical restraints.
- Assuring that physical restraints should be prescribed and documented in medical records.

5. Conclusions

Physical restraints are an important part of nurses' work Physical restraints are a threat to patients' dignity, self-concept, and autonomy, which conflicts with the core principles of the code of ethics. "Physical restraint" argues with its aim of preventing harm that may cause physical and psychological harm to restrained patients. Furthermore, it could be perceived as punishment if the health care providers threaten the patients with restraining them which simply will result in destructive behaviors against the health care providers. If it is necessary to use the restraints, the health care professionals should involve the family members in this decision.

Ethical approval

Ethical issues are not involved in this paper.

Conflicts of interest

All contributing authors declare no conflicts of interest.

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