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USING RESTRAINT

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Mr. Kern, at age 80, was hospitalized for pneumonia. He occupied that gray area in which one is unsure whether or not he was competent. He knew his name and the names of his family members. He also knew that he was in a hospital, and he could appropriately answer any ordinary question put to him. On the other hand, he could not name the president of the United States nor the hospital he was in. Nor could he remember the name of any nurse or physician attending him. That he had at least some understanding of what he was told was clear. What was unclear was the depth of that understanding. Since Mr. Kern was unsteady, the nurses appropriately judged that he might fall if allowed to walk unassisted. They instructed him to call for a nurse when he wished to leave the bed. He repeatedly promised to do so. Nonetheless, during their frequent checks on Mr. Kern, nurses found him wobbling across the room to the bathroom. Various strategies were tried to encourage Mr. Kern to use the call light to request assistance: He was put near the nurses' station. Nurses responded promptly to his occasional use of the call light. His side rails were always left up to dis- courage easy exits from the bed. But nothing worked. Ultimately, the nurses decided to do what most of us would do- they restrained Mr. Kern so that he was physically unable to leave his bed. They pointed out that restraints were the only way to pre- vent his solo walks, that these walks could very well lead to a fall, and that a fall could be disastrous to Mr. Kern. All these points are true. But does it follow that re- straining Mr. Kern was right? As nurses we take our obligations seriously, and keeping patients safe is taken to be our fore- most obligation. All other concerns defer to safety. At least that is the view of most nurses. This principle of "safety first" appears unobjectionable. Yet it is not a principle we apply, or would want applied, to our own lives. Unthinking adherence to this principle in nursing practice has dubious if not pernicious effects. Sometimes our best interests involve risking our safety for some other value. Such risks are everyday occurrences. We drive cars for convenience, not because they are the safest mode of transportation. Some people ski for fun although watching television is safer. People quite rationally risk their safety and sometimes their lives for money, fun, fame, love, or a cause they believe in. In general, when a course of action is risky, our duty as health professionals is to point out the risks. But whenever possible we should not decide for patients which risks are worth taking. After all, their views may differ. Nurses described their restraint of Mr. Kern as ensuring his safety. It is important to see, however, that for Mr. Kern there were bene- fits, as well as potential harms, in his solo walks. Applying the principle of "safety first" involves judging such benefits as well as the probability and cost of the potential harm. How did Mr. Kern benefit from making his own way to the bath- room? First, he didn't have to wait for someone to answer the call light. Even when nurses attempted to respond quickly, at times some wait was unavoidable. At 80, waiting to urinate, besides causing dis- comfort, risks the indignity of in- continence. Having to call for help also underscored his dependency. For some this dependency may itself be experienced as an indignity. These considerations can't be brushed off lightly, even if we don't judge them to outweigh the possibility of great harm from a fall. But some will argue that Mr. Kern is not making a judgment, that he is simply forgetting to use the call light. The restraints don't override his will

so much as fill in for his failing memory. Were he fully competent, the argument goes, he would agree that the inconvenience of the wait for help was worth the reduced chance of a broken hip. But if Mr. Kern does need to be restrained, we must compare the possible harm from a fall to the dis- comfort and indignity of being tied to a bed. How many of us would want to be tied to our beds, perhaps indefinitely, to ensure that we wouldn't hurt ourselves? Even if a fall and broken hip became great probabilities, if the only prevention were restraint, the cure might well be worse than the disease. Instead of being guided by the principle of safety first, what about being guided by the principle of freedom first or comfort first or dignity or autonomy or even happiness first? Are these principles more appropriate? Is it always better to invoke the principle of safety and ignore the principles that foster other values? These questions are important because nurses often find themselves in the position of judging what is in the overall best interests of their patients. But if the decent respect nurses hold for health and safety becomes the narrow view that there is no more to life than health and safety, poor judgments will abound. Ideally, nurses would avoid, as far as possible, substituting their judgments for their patients' judgments about their patients' best interests. Where a nurse is required to judge for an incompetent patient, she must step out of her role as a health and safety specialist and represent to herself the full range of the patient's interests. Even from the narrow perspective of health care, the principle of safety first is questionable. Besides conflicting with other non-health values, a policy of restraining Mr. Kern could be injurious to his health. When someone is restrained, muscles atrophy, skin breaks down, and agitation and confusion increase. Safety, of course, is important. Some dangers are so grave that virtually no other goal should take precedence over their prevention. And a safe environment allows one to pursue other goals. But, however understandable, it is nonetheless a mistake when a safe environment is achieved at the expense of the very goals it allows you to pursue: "Mr. Kern will lose his mobility if he breaks a hip, so we will tie him down to pre- vent the loss of mobility." While a mistaken analysis of the patient's interest plays a large role in upholding the safety-first principle, it is not the only, and per- haps not the most important, factor. At times, the principle may be a rationalization of motives less acceptable-namely, nurse safety and convenience. By nurse safety, I mean legal safety. Nurses, if they have a physician's prescription for restraints, never get in trouble for using that permission. Too often, nurses interpret their "responsibility" to refer to those things for which they can be held legally responsible. And nurses are never held legally responsible for the overall well- being of the patient, although they commonly are held legally responsible for broken hips. Eliminating the risk of a broken hip, even if it means eliminating the client's dignity, is legally prudent for a nurse. Moreover, making a patient safe usually has the side effect of making him less bother- some. It is difficult to know how much we are concerned with the danger and how much with the bother. In all fairness, these unattractive motives are engendered by forces not of the nurse's making. Nurse educators and supervisors are constantly stressing the litigious nature of the work situation. Nurses are almost taught to believe that avoiding a lawsuit is their most important task (and not an easy one to accomplish).

If nurses try to reduce their work- loads, it is because they are so overworked. Too often, staffing is so inadequate that nurses are driven to making work-saving strategies central to their practice. If a patient is tied down for a nurse's convenience, it is not for the convenience of drinking coffee and reading newspapers but for the "convenience" of seeing to other patients' needs. Of course, safety should play a prominent role in nursing, but not the role of a tyrant. We can avoid its oppressive tendencies by O wherever possible letting the patient decide whether a safety risk (that the patient understands) is worth taking; O being mindful that we often ensure safety by

sacrificing other values, and that sometimes those other values are actually worth more than what we achieve, and O being clear and honest about what is done for the sake of the individual patient versus what is done for the sake of nurses, physicians, or the institution. There are times when a particular patient's interests are out- weighed by other considerations. However, unless we are honest about our motivations, we will be unable to distinguish the legitimate cases from others which are not. It is time to challenge the nursing orthodoxy of "safety first" and the abuses this dogma engenders. Such a challenge will make the most humane of professions more humane still.