Ethics Corner: Cases from the Hebrew Rehabilitation Center for Aged—Restraint Complaint

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This article is the third of a six-part JAMDA series devoted to medical ethics in the nursing home. In each issue, a case is presented from the Ethics Committee at the Hebrew Rehabilitation Center for Aged (HRCA) in Boston, Massachusetts. After a description of the case and a discussion of the ethical issues that the case raises, Dr. Steven Levenson discusses the implications for medical directors.

CASE PRESENTATION

The Ethics Committee was asked to consult on the case of Frederick N., an 81-year-old, Russian-speaking man transferred to the HRCA from another nursing home. Mr. N. had been diagnosed with vascular dementia 6 years before his admission, and the dementia had progressed to the point where Mr. N. was totally dependent on caregivers for personal hygiene and dressing. In addition, Mr. N. received nourishment through a percutaneous endoscopically placed gastrostomy (PEG) tube that had been inserted 5 months before his admission to the HRCA. His other medical problems included a history of pulmonary embolism with subsequent inferior vena cava filter placement, congestive heart failure, right parietal meningioma, gallstone pancreatitis, recurrent urinary tract infections, and recurrent falls.

Mr. N. was born and raised in Moscow. He received the equivalent of a high school education, served on the Russian front in World War II, and later worked as a butcher. He married at age 28 and had one child. Mr. N.’s wife died in 1994, and he immigrated to the United States with his son in 1998. Mr. N. initially lived with his son’s family but was placed in a nursing home when his needs became more than the family could manage. On two occasions before his nursing home admission, Mr. N. had wandered from his home. A transfer note from the nursing home to HRCA indicated that Mr. N. was often placed in chairs with lap belts because of his intermittent attempts to get out of his wheelchair. At the time of transfer, Mr. N. had sutures in his forehead from a recent fall and laceration. On a Mini Mental Status Exam conducted in Russian, Mr. N. scored 7/30.

Mr. N. was admitted to a unit at HRCA that specializes in care of patients with advanced dementia. At the time of admission, Mr. N.’s son was adamant that the team continue to use a lab belt with his father. The team members reluctantly continued the lap belt until they became more familiar with Mr. N. Mr. N.’s first 2 months at HRCA were complicated by hospitalizations for a gastrointestinal bleed and pneumonia. He would occasionally pull out his PEG tube. At the HRCA, staff observed that Mr. N. would try to stand up and walk without assistance. The staff felt that he was at high risk for falling because of poor judgment and impaired visuospatial orientation. The lap belt did seem to have a deterrent effect, and it was continued. Over the next 2 months, however, Mr. N.’s medical condition stabilized, his eating improved, and he was weaned from his PEG tube feedings. Mr. N.’s strength likewise improved. The treatment team became concerned that Mr. N.’s lap belt was placing him at increased risk for injury, because Mr. N. was now able to lift the chair to which he was belted when he attempted to walk. The treatment team conducted a restraint review meeting and developed a plan to recommend removal of the lap belt to Mr. N.’s son. The plan included continuing the current schedule of providing Mr. N. several accompanied walks each day. In a meeting with Mr. N.’s nurse, Mr. N.’s son expressed misgivings but reluctantly agreed to the plan. The treatment team requested a consultation on its plan by the Ethics Committee before removing the lap belt.

The Ethics Committee observed Mr. N. on his unit and interviewed members of the treatment team. Mr. N. was not able to communicate in a meaningful way with the ethics consultants, even with the assistance of a Russian interpreter. Members of the team commented on the change of affect they observed in Mr. N. when they took him for walks. On these occasions, his countenance brightened, and he gave the impression of being pleased with his independence. There was consensus within the team that they were doing the “right thing” by Mr. N. However, members of the team were con-
concerned about the possibility of being blamed were Mr. N. to fall and injure himself. In a review of Mr. N.’s medical record, the ethics consultants made note of the fact that Mr. N. was the only resident on his unit whose code status was “full code.”

The Ethics Committee also reviewed its institution’s policies on physical restraints. The Committee members noted that HRCA policy provided for the use of physical restraints only on a temporary basis in the event of acute risk for self-harm. The Committee observed that Mr. N.’s treatment team had complied with the institution’s policies regarding review and documentation of restraint use. The Ethics Committee expressed its support for the treatment team’s plan and observed that Mr. N.’s case raised the issues discussed below.

**CASE DISCUSSION**

In the case of Mr. N., the treatment team consulted the Ethics Committee to obtain endorsement of a care plan that the team believed was both ethically and medically appropriate but was resisted by the resident’s decision maker. Mr. N.’s case raises issues related to the ethical principles of autonomy and non-maleficence. The case also raises medico-legal issues and issues of cultural sensitivity.

**Autonomy**

Mr. N. lacked the capacity to articulate preferences, and his insight into the possible consequences of walking unassisted was diminished at best. Mr. N. had not completed advance directives (and even if he had, it is unlikely he would have addressed the issue of walking when falls became a risk). In conferring with Mr. N.’s son before instituting a change in Mr. N.’s care plan, the team was respecting Mr. N.’s right to autonomous decision making via his surrogate. Although Mr. N.’s son had misgivings about removing his father’s restraint, the Ethics Committee found no indication that the team had coerced the son. The son had the option of appealing the team’s decision to an administrator if he was dissatisfied with the team’s plan.

Until recently, the challenges to autonomy that are distinct to the long-term care setting received scant attention in the bioethics literature. Most discussions of the importance of respecting autonomy in medical decision making have been confined to the acute care environment. They have focused on decision making surrounding life-sustaining treatment. What is needed, Caplan and others have proposed, is a bioethics that applies to the less dramatic but also important every day decisions that are a reality of long-term care.

“On a day-to-day basis, the kind of issues that the residents of nursing homes confront . . . are matters that at first glance appear mundane or banal. . . . It may seem odd at first even to describe such questions as moral or ethical. But ethics concerns not only questions of life and death but how one ought to live with and interact with others on a daily basis. The ethics of the ordinary is just as much a part of health care ethics as the ethics of the extraordinary. For the resident, the small decisions of daily life set the boundaries of his or her moral universe.”

For a resident whom has already forfeited considerable independence by virtue of institutional long-term care, exercising choice in areas such as walking can be personally meaningful. Viewed in this light, autonomy has not only instrumental value in decision making but intrinsic value in helping to preserve for an individual a sense of personhood.

Conversely, restricting the ability of the nursing home resident to make choices in his daily life can lead to passivity, withdrawal, and depression.

Fostering a resident’s autonomy in the long-term care setting requires a commitment by facility staff to ascertaining the priorities of each individual. It fell to the treatment team to convey to Mr. N.’s son their observations of Mr. N.’s evident satisfaction when he was walking. In the case of a resident who is unable to articulate preferences, surrogate decision makers and staff must strive to understand past priorities and values. “One must look at the activities that the individual has engaged in and how enthusiastically or reluctantly she participated, as well as the person’s previously stated goals and motivations in order to determine whether or not a decision is autonomous by this standard.”

The team thus also had a role in helping the son apply his knowledge of his father’s past preferences to the situation at hand.

Closely related to autonomy and deserving brief mention is the principle of liberty. Discussions of liberty have less relevance to the bioethics of acute medical care; in the hospital, patients willingly submit to what are understood to be temporary deprivations of liberty in the interest of receiving intensive medical treatment. As Collopy and others have emphasized, nursing homes are truly homes for their residents. As such, nursing homes have a responsibility, to the extent possible, to maximize liberty.

**Nonmaleficence**

The treatment team’s decision to remove Mr. N.’s lap belt was precipitated in large part by the observation that, with his increased strength, Mr. N. was lifting up the chair to which he was belted. The physical restraint was therefore increasing Mr. N.’s risk for incurring the very thing it was supposed to be preventing—fall and injury from fall. The treatment team’s plan was therefore justifiable on the basis of protection of Mr. N. from harm.

A burgeoning literature on the effects of restraints on falls has repeatedly demonstrated that restraints are unsuccessful in preventing injurious falls. An observational study of 397 residents of Connecticut nursing homes found that over a 1-year period, 5% of unrestrained residents had serious, fall-related injuries compared to 17% of restrained residents. When the relationship between restraint use and falls was examined controlling for the use of psychoactive medications, there was no evidence that restraints prevented falls. Finally, studies of the effect of restraint-reduction programs in nursing homes have not shown an increased risk of falls in nursing homes that have successfully engaged in restraint-removal.

**Legal Considerations**

Underlying the treatment team’s concern that it might be blamed for a subsequent injury to Mr. N. was the fear of litigation. As noted above, the Ethics Committee’s assessment determined that the treatment team’s review and documen-
tation of the use of restraints, as well as the plan to discontinue the restraint, complied with its institution’s restraint policy. While a review of the restraint reduction movement in this country is beyond the scope of this article, some key points deserve mention. Before enactment of the Nursing Home Quality Reform Act of the 1987 Omnibus Budget Reconciliation Act (OBRA), the proportion of nursing home residents who were restrained had reached 41%. The restraint guidelines of OBRA 1987, which went into effect in 1990, reflected awareness of the direct physical dangers of restraints as well as associated medical complications (eg, skin breakdown, muscle wasting, infection). However, the legislation was also motivated by concerns about resident freedom, dignity, and psychological health. OBRA 1987 requires that physical restraints be used only as a last resort when a resident is in immediate danger and mandates that ongoing attempts be made to remove the restraints.

Reviewers of case law have found a dearth of successful suits against nursing homes that have removed restraints in compliance with OBRA 1987. Kapp reviewed reported cases decided between 1995 and 1998 involving allegations of professional negligence around use or failure to use physical restraints. He concluded that “restraint reduction or elimination is likely to create legal risk management benefits (italics added) for providers in addition to producing salutary clinical, psychological, ethical, and financial effects for both providers and residents.”

Communication and Cross-cultural Issues

Mr. N. and his son immigrated to the United States relatively recently, which raises the possibility of cross-cultural issues contributing to the case. The first issue to consider is the possibility of a language barrier. Although Mr. N.’s son spoke English, it was not his first language. Educating a family member about ethical concepts such as substitute decision making and autonomy can be a challenge under the best of circumstances; adding a language barrier further complicates the process.

Culturally effective care is widely held to require cultural sensitivity and cultural competence on the part of physicians and other caregivers. Cultural sensitivity involves attitudes—an awareness of and respect for cultural differences. Cultural competence involves knowledge and skills—specific understanding of the patient’s cultural beliefs and views of health and disease as well as sophistication in communication. In the case of Mr. N., awareness of the family’s experience and beliefs might have influenced the team’s approach. An émigré from the Soviet Union may be used to dealing with an authoritarian and paternalistic health care system in which patients were not included in treatment decisions. A Russian émigré may question the competency of a provider who involves him in a conversation about treatment rather than making a unilateral decision. A Russian émigré may also be uncomfortable working with nonphysician members of the treatment team. Russians have traditionally viewed nurses as middle-level personnel not involved in treatment planning. Social workers did not exist in the Soviet health care system. Finally, Russian culture values beneficence over autonomy in matters pertaining to medical decision making. This may lead, for example, to a scenario in which a Russian family requests that a treatment team not inform a competent parent about a diagnosis of cancer. The treatment team’s awareness of this may have led to the understanding that the family valued safety over independence.

Another approach to cross-cultural sensitivity that may be useful in the case of Mr. N. is the cultural engagement model. This strategy is based on three principles: mutual respect (requiring that all persons see themselves as equal with respect to their humanity and dignity), the principle of vulnerability (the assumption that patients are vulnerable by virtue of illness and the ways they are treated by caregivers), and the principle of cultural relevance (importance of the patient’s interpretation of his illness experience). Ethics consultants can help narrow the gap between patient and provider by clarifying the explanatory models of disease of both parties: this can be achieved by asking both the physician and the patient or family member to identify what the health problem is, what causes the problem, what has been done about the problem, and what the concerns are for the future.

In the case of Mr. N., the physician (health care team) saw the patient as having advanced dementia with poor judgment. Mr. N. was felt to derive enjoyment from walking and to have sufficient strength and gait stability to walk with assistance. The team also believed a lap belt to constitute a restraint that was morally objectionable, that was unlikely to prevent falls, and that might increase Mr. N.’s risk of an injurious fall. Finally, the team members were familiar with the data indicating vanishingly small success rates of cardiopulmonary resuscitation in nursing home patients with advanced dementia. Mr. N.’s son, by contrast, may have thought his father had normal age-related “senility.” While he could see that his father liked walking and did not like to be confined to a wheelchair, he may have viewed the lap belt as analogous to a car seatbelt and of similar efficacy. Finally, Mr. N.’s son, not unlike many Russian émigrés, may have an idealized view of technological advances in American medicine. Mr. N.’s son may well have assumed that if cardiopulmonary resuscitation was an available option, it must be an effective therapy and that a “DNR” status would deprive his father of legitimate, life-prolonging treatment.

In the situation confronting Mr. N.’s team, sensitivity to the values and beliefs of the son would probably not lead the team to change their position on restraint removal. Such sensitivity might, however, help the son appreciate the basis of the team’s care plan and might lead to more willing acceptance. Sensitivity of this kind cannot help but improve communications between family and caregivers and may lead to smoother dialogue when other medical decisions must be made.

CONCLUSION

In the case of Mr. N., the role of the Ethics Committee was to provide reassurance around a decision the treatment team believed was ethical rather than to help the team through an impasse. The Ethics Committee was able to bolster the team’s confidence in their plan by illustrating that the plan that they intuitively believed was right was consistent with medical ethical principles and current legislation. Problems with com-
Communications are often a contributing factor in cases referred to the Ethics Committee. In the case of Mr. N., the Ethics Committee identified differences in values that might exist between the team and Mr. N.’s decision maker, which may impede the working relationship.

REFERENCES

8. MacLean DS. Restraining the use of restraints. Caring for the Ages 2001; December 6–8.