Presidenza del Consiglio dei Ministri

COMITATO NAZIONALE
PER LA BIOETICA

Abstract

MEDICAL RESTRAINTS: BIOETHICAL ISSUES

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The Opinion, “Medical restraints: bioethical issues”, addresses the issue of medical restraint as it is used on psychiatric patients and the elderly, with particular focus on the mechanical forms of restraint, which raise the major ethical and juridical issues.

Several stances of international organisations and the NBC itself in previous Opinions (on mental health and assistance to the elderly) have already clearly pointed out the goal of overcoming medical restraint, which has to be considered a remnant practice from the culture of mental institutions. Nonetheless, such practice still appears to be used, and in no way as an exceptional measure. Although useful incentives are offered by experiences of non-restraint care, which have chosen not to apply mechanical restraint as good practice, they are still very limited. Moreover, there is the lack of adequate public and institutional attention to such a serious problem, which comes to the fore when a person being restrained dies in tragic consequences.

Despite the lack of studies on the issue, some references to this emerge from the research on the variables mostly affecting the resorting to medical restraint: the culture, the organisation of services and the approach of the mental healthcare professionals play a more crucial role than the seriousness of patients’ health conditions and psychopathological profile. This shows that it is possible to avoid restraining patients and the success of studies aimed at monitoring and reducing this practice confirms this.

For these reasons, the NBC reaffirms the bioethical standpoint of the overcoming of the practice of restraint, within a new paradigm of care based on the identification of the person as such (more than as a sick person), in their full rights. The respect for the autonomy and dignity of the person is also the prerequisite for an effective therapeutic intervention. Conversely, the use of force and restraint, as such, represents a violation of the fundamental rights of a person. The fact that, under really exceptional conditions, health professionals can resort to justifications for applying medical restraint does not take away from the rule of non-restraint, nor does it modify the foundations of the ethical discourse.

Legally speaking, since fundamental personal rights are at stake, it is important to stress the strict limits of the justification for medical restraint. The use of mechanical restraint techniques must represent the last resort and can be applied, taking also into consideration the context of the Compulsory Healthcare Treatment, only in situations of actual necessity and urgency, proportionally to concrete needs, using the least invasive methods, and only for the amount of time needed to overcome the triggering conditions. In other words, the fact that the patient is in a state of mere agitation cannot be considered a sufficient condition for medical restraint to be justified, instead, a *serious and real* danger must exist that the patient carries out self-harming acts or commits an offence against third parties. At the time when such a danger no longer exists, the restraining treatment has to be ended, as it would no longer be justified by necessity and it would amount to potential criminal conduct.

In its conclusions, the NBC furthermore recommends: *an increase in research* on the issue, also in the case of the elderly who are the most defenceless individuals against coercive practices; *the setting up of specific monitoring*, at regional as well as national levels, starting from daily practices

carried out within hospital wards, where cases of medical restraint have to be rigorously recorded, together with the precise reasons leading up to the choice of restraining the patient, and the duration of the measure adopted; *the introduction of programs aimed at overcoming medical restraint* in the context of a general culture of care that is respectful of rights, by acting on services-organisation models and staff training; *the introduction of quality standards in the evaluation of services*, in order to foster non-restraint services and settings; *the keeping and possible increase of the diffusion and quality of services for the most vulnerable individuals*, as they are more likely to be subject to inhuman and demeaning practices.