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Use of Restraints in the Hospital Setting: Is the Law a Help or Hindrance to the Advancement of Changing Medical Ideology?

Beth A. Buchanan Staudenmaier
University of Dayton

USE OF RESTRAINTS IN THE HOSPITAL SETTING: IS THE LAW A HELP OR HINDRANCE TO THE ADVANCEMENT OF CHANGING MEDICAL IDEOLOGY?

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I. INTRODUCTION

"I felt like a dog and cried all night. It hurt me to have to be tied up. I felt like I was nobody, that I was dirt. It makes me cry to talk about it (tears). The hospital is worse than a jail."

Interview with 72 year old male patient.[1]

The use of physical restraints in the hospital setting has historically been considered an acceptable medical practice.[2] On average, approximately one out of every nine adults will be physically restrained during a hospital stay.[3] This statistic increases to one in five if the patient is over 65 years of age.[4] Yet recently, numerous clinicians and others are advocating for a reduction in the use of physical restraints. Their recommendations are based on various detrimental physical and psychological side effects resulting from the use of physical restraints, as well as moral and ethical considerations. Studies of other nations' use of physical restraints in the hospital setting likewise reveal that reform may be warranted. In a recent investigation of three European hospitals, not one patient was physically restrained, even in the intensive care

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1. Wayland Marks, M.D., *Physical Restraints in the Practice of Medicine*, 152 ARCHIVES INTERNAL MED. 2203, 2204 (1992).

2. The scope of this Comment is limited to an analysis of the use of *physical* restraints in general acute care hospitals. The use of *chemical* restraints and the use of physical restraints in nursing homes, long-term care facilities, mental hospitals, or prison hospitals raise separate and unique issues that are beyond the scope of this Comment.

3. *See* Lorraine C. Mion & J. Dermot Frengley, *Physical Restraints in the Hospital Setting*, *in* TOWARD A RESTRAINT-FREE ENVIRONMENT 127 (Judith V. Braun & Steven Lipson, eds., 1993) (stating that in the acute care setting, about 6%-17% of patients have been restrained at some time).

4. For patients over 65 years of age, 18%-20.3% have been restrained. *Id.*

units.[5]

In spite of this growing trend to reduce the use of physical restraints, many physicians, nurses and administrators are hesitant to alter the current practice of using restraints. Although various reasons are offered in support of the current practice, by far one of the most prevalent responses is fear of liability for *failing* to restrain a patient. This fear is described by one commentator as a perceived "legal prophylaxis for providers and institutions."[6] This form of "defensive medicine" is not implemented primarily for the best interests of the patient but for the presumed protection of the providers. Unfortunately, legal liability is a very real consideration for health care providers and understandably affects the methods of treatment they prescribe.

The common law offers little reassurance to health care providers as courts differ on what is the applicable standard of care regarding the issue of restraints. Under the medical malpractice approach, health care providers have the opportunity to establish the requisite standard of care based on expert testimony.[7] Under the ordinary negligence approach, however, the jury determines the standard of care based on its own "common sense" approach to the facts of each case.[8] Unfortunately, it is not possible for health care providers to anticipate which approach the court will adopt.

This Comment concludes that legislative action will be necessary to address the health care providers' fear of liability for failing to restrain patients. Section II provides the medical rationale behind the growing desire to reduce the use of physical restraints in the hospital environment.[9] Section III addresses the potential legal ramifications of a decision to reduce the use of physical restraints in the hospital setting. This section analyzes the manner in which the courts address the issue of restraints in the hospital setting and the implications this may have on any change in medical practice.[10] Further, Section III offers suggestions for legislation that will help accomplish the desired goal of the reduced use of physical restraints in the hospital setting.[11] Section IV concludes that appropriate legislation can set the stage for reduction in the use of physical restraints.

II. BACKGROUND

A physical restraint is "any manual method or physical device, material, or equipment attached or adjacent to a patient's body that restricts freedom of

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5. *See* Lorraine C. Mion, et al., *Physical Restraint in the Hospital Setting: Unresolved Issues and Directions for Research*, 74 MILBANK Q. 411, 413 (1996); *see also* Marks, *supra* note 1, at 2204 (observing that "in Europe restraints are seldom found to be necessary").

6. *See* Mion, *supra* note 5, at 423.

7. *See infra* notes 53-57 and accompanying text.

8. *See infra* notes 49-52 and accompanying text.

9. *See infra* notes 12-41 and accompanying text.

10. *See infra* notes 42-70 and accompanying text.

11. *See infra* notes 71-84 and accompanying text.

movement or normal access to one's body."[12] Such devices may include Posey belts,[13] arm, leg or waist ties, soft mitts, bed rails and restraining chairs.[14] Both physicians and nurses, depending upon state and hospital regulations, make decisions regarding the necessity of restraints for hospital patients.[15] Factors that are considered in making this assessment include: the patient's age, his or her physical and mental condition, severity of illness, presence of medical devices, and current medication.[16]

While the use of physical restraints has a long history in medical tradition,[17] a growing number of health care providers are critically opposed to the extensive use of restraints. The Omnibus Budget Reconciliation Act (OBRA) of 1987[18] is illustrative of the current movement to reduce the use of restraints.[19] OBRA provides that nursing home residents have a right to be free of restraints, and the Act places the burden on health care providers to substantiate the need for restraint.[20] Despite this growing movement, many health care providers are skeptical of any changes in the status quo. These health care providers cite numerous preventative reasons, both medical and legal, in support of the continued use of restraints.[21]

A frequently articulated response is the desire to protect the patient and others from injury. Specifically, health care providers state that they use physical restraints to prevent falls, disruption of medical devices, such as intravenous lines, respirators, feeding tubes, or catheters, and to control agitated behavior or wandering.[22] In addition to concerns regarding patient safety, many health care providers likewise state concerns over potential increased costs and fear of litigation from a reduction of the use of physical

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12. *See* Marshall B. Kapp, *Physical Restraint in* Hospitals: Risk *Management's Reduction Role*, 14 J. HEALTHCARE RISK MGMT. 3, 3 (1994).

13. A "Posey belt" is a "strap which goes around a patient's waist to be fastened under the bed or to its sides in a manner which permits the patient to turn from side to side, but prevents [the patient] from getting out of the bed." Dollins v. Hartford Accident & Indem. Co., 477 S.W.2d 179, 181 (Ark. 1972).

14. *See* Kapp, *supra* note 12, at 3; Marks, *supra* note 1, at 2203.

15. *See* Mion, *supra* note 5, at 414-15.

16. *See, e.g.*, Mary O'Reilly Yob, *Use of Restraints: Too Much or Not Enough?*, 15 FOCUS ON CRITICAL CARE 32, 33 (1988) (listing factors to be considered in assessing whether to restrain a patient); *Dollins*, 477 S.W.2d at 180-81 (confused patient on anti-convulsant medication).

17. *See* May L. Wykle, *An Overview of Restraint Use and the Movement to Reduce the Use of Restraints*, *in* TOWARD A RESTRAINT-FREE ENVIRONMENT 3 (Judith V. Braun & Steven Lipson, eds., 1993) (observing that devices such as the "tranquilizing chair," which are intended to restore a patient's mental stability, date back as early as the late eighteenth century).

18. 42 U.S.C. § 1396r (1994).

19. *See* Wykle, *supra* note 17, at 3 (observing that the "reform movement [of the 1980s] to 'untie the elderly' in nursing homes . . . spurred—and was in turn spurred by—the passage of the Omnibus Budget Reconciliation Act").

20. *See* 42 U.S.C. § 1396r(c)(1)(A)(ii) (stating that restraints may be used only to "ensure the physical safety of the resident or other residents, and only [on] the written order of a physician that specifies the duration and circumstances [of the restraints]"); *see also* Wykle, *supra* note 17, at 3 (noting OBRA and its regulations prescribe the use of restraints only for a patient's treatment and prohibit the use of restraints for the convenience of the staff or to discipline a patient).

21. *See infra* notes 22-23 and accompanying text.

22. *See, e.g.*, Marks, *supra* note 1, at 2204.

restraints.[23]

On the other hand, those who advocate for a reduction in the use of physical restraints believe that the detrimental side effects from the use of physical restraints in many instances outweigh the perceived beneficial aspects of their use. These proponents observe that studies fail to support the belief that restraints protect patients from injury.[24] In fact, the use of restraints frequently *causes* serious injury.[25] Potential harmful physical side effects from the use of restraints include decreased mobility from loss of muscle strength, skin abrasions, ulcers, and various infections.[26] Further, serious side effects, such as nerve damage, amputation, and even death, can result from the use of physical restraints.[27] In addition to physical side effects, numerous detrimental psychological side effects are frequently associated with physical restraints. For example, patients frequently experience a sense of fear and humiliation that may manifest itself as anger, agitation, or depression.[28] Finally, some observers note there may be a correlation between the use of physical restraints and the use of chemical restraints.[29] If a patient becomes agitated while physically restrained, it may become necessary to sedate the patient; conversely, if a patient is sedated, the patient may need to be restrained because of the patient's decreased physical and cognitive ability.[30]

In addition to the physical and psychological trauma that may result, proponents for the reduction of physical restraints observe that patients have inherent human rights—rights to freedom of movement and individual choice in the direction of their treatment—that are not forfeited upon admission to a

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23. *See* Charles D. Phillips, Et. Al., *Reducing the Use of Physical Restraints in Nursing Homes: Will It Increase Costs?*, 83 AM. J. PUB. HEALTH 342, 342 (1993) (stating some health care providers resist reform fearing it will be prohibitively costly to implement); Marks, *supra* note 1, at 2204 (stating a frequent reason for the use of restraints is "fear of liability should the patient subsequently fall and injure [him or herself]"); Yob, *supra* note 16, at 32 (stating nurses express concerns about liability for decisions pertaining to restraints).

24. *See* Sandra H. Johnson, *The Fear of Liability and the Use of Restraints in Nursing Homes*, 18 LAW, MED. & HEALTH CARE 263, 263 (1990) (observing that "[r]esearch has yet to provide an empirical basis to support the customary uses of restraints").

25. *See, e.g.*, Kapp, *supra* note 12, at 4 (noting the various physical, cognitive, and psychological side effects that can result from the prolonged use of restraints, improper application of the restraint, or the failure to monitor the restrained patient).

26. *See* Johnson, *supra* note 24, at 263 (observing risks associated with restraint use include medical ailments caused by immobility); Kapp, *supra* note 12, at 4 (observing risks associated with restraint use include "difficulties with [the] skin, the gastro-intestinal and genito-urinary systems, respiration, blood circulation, and musculoskeletal functioning . . . [and] nosocomial infections"); Marks, *supra* note 1, at 2204 (observing risks associated with the use of restraint include "physical deconditioning; sensory deprivation; decreased muscle mass, tone and strength; increased osteoporosis; nosocomial infection; urinary and fecal incontinence; skin abrasions; and pressure ulcers").

27. *See* Johnson, *supra* note 24, at 263 (observing that strangulation is a serious risk associated with restraint use); Marks, *supra* note 1, at 2203 (observing that strangulation, impaired circulation and nerve damage are serious risks associated with the use of restraints).

28. *See* Johnson, *supra* note 24, at 263 (observing that increased agitation is a risk associated with restraint use).

29. *See* Mion, *supra* note 5, at 419-20.

30. *Id.*

hospital.[31] These factors create an "ethical dilemma": how to protect patients' safety while at the same time preserving their autonomy.[32] Some advocates for the reduction in the use of physical restraints suggest that a better balance can be found between these conflicting goals than currently exists.[33] While acknowledging that restraints are warranted in certain situations,[34] these proponents note that several measures exist that reduce the risk of injury while preserving the patient's freedom of movement.[35]

Certain physical changes can be made to the hospital surroundings themselves.[36] For example, increased lighting, carpeting, grab bars, lowering beds, and removing wheels from furniture may help to prevent falls.[37] Placing a patient closer to the nursing station and installing various alarm devices may prevent wandering.[38] Agitation may be reduced by providing patients with activities, reducing noise levels, allowing patients to personalize the hospital setting by decorating their rooms with small personal objects brought from home, and permitting family members greater access to the patient.[39] Additionally, where restraints *are* necessary to protect patients due to medication or to prevent the disruption of medical devices, physicians should frequently reevaluate the patient's status and discontinue the use of the medication or medical devices as soon as possible.[40] Finally, for staff members who work with behaviorally disturbed patients, hospitals should provide support such as counseling, altering patient assignments and providing staff training.[41]

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31. Marks, *supra* note 1, at 2205 (observing that the "patient is a moral agent with the same basic human rights afforded [to] all of us [and] [e]ntry into a hospital or nursing home does not forfeit these rights").

32. *See* Johnson, *supra* note 24, at 264 (observing that restraints "present a dilemma [involving] . . . 'primal philosophical and experiential tensions: between freedom and best interest, self-determination and dependence on others, individual choice and the pressures of collective care'") (quoting Callopy, *Autonomy in Long Term Care: Some Critical Distinctions*, 28 GERONTOLOGIST 10, 10 (1988)); Marks, *supra* note 1, at 2203 (observing a conflict between autonomy and safety); Yob, *supra* note 15, at 33 (observing that decisions to restrain involve a balancing between "the patient's safety needs against the patient's right to freedom of movement").

33. *See, e.g.*, Marks, *supra* note 1, at 2205 (advocating the least restrictive methods of restraint and long term health care alternatives).

34. *See id.* at 2206 (noting that restraints may be necessary in "emergency situations" such as to protect medical devices from removal by postoperative delirious patients or where the delirious patient poses a risk of injury to themselves or others).

35. *See, e.g.*, Johnson, *supra* note 23, at 264.

36. *See* Patricia Carter & Vivian J. Koroknay, *Environmental and Nursing Alternatives to Physical Restraints*, *in* TOWARD A RESTRAINT-FREE ENVIRONMENT 75-92 (Judith V. Braun & Steven Lipson, eds., 1993).

37. *See* Mion & Frengley, *supra* note 3, at 132-43 (providing detailed alternatives to physical restraints for the prevention of falls, protecting or maintaining medical therapy, wandering, agitation, and disruptive behavior).

38. *Id.*

39. *Id.*

40. *See* Marks, *supra* note 1, at 2206.

41. *See* Kapp, *supra* note 12, at 6.

III. ANALYSIS

A frequently cited reason for restraining a patient is fear of liability for injury to a patient or others caused by failure to restrain the patient. Research indicates that this fear is not entirely without merit. In forty-nine verdicts regarding restraint of hospital patients, only six involved injuries from restraints while the remaining forty-three involved either a failure to restrain or inadequate restraint of a patient.[42] In the injury-*from*-restraint verdicts, health care providers were found liable in two instances (33%), not liable in three instances (50%), and the remaining case was settled (17%). Damages in these cases ranged from $50,000 to $1,200,000. In the failure-*to*-restrain verdicts, health care providers were found liable in eighteen instances (42%), not liable in nineteen instances (44%), and settled the remaining six cases (14%). Damages ranged from $13,000 to $1,415,000.

An examination of reported opinions revealed similar statistics.[43] Of the sixty cases involving restraints in the hospital context, only five involved alleged injuries from restraints while the remaining fifty-five cases involved injuries from allegations of failure to properly restrain[44] the patient. Health care providers were found liable in twenty-three (42%) of the failure-to-adequately-restrain cases and in three (60%) of the injury-from-restraint cases. Accordingly, health care providers have a sound basis for their concern regarding the legal implications of the use of physical restraints.

This section first examines how courts approach actions involving the use, or lack thereof, of physical restraints. This analysis will reveal that the common law does not provide the necessary assurances to health care providers to overcome the perceived fear of litigation. Finally, this section suggests legislative methods that will both provide assurances to health care providers and protection of patient rights.

A. Common Law Approach to Restraints in the Hospital Setting

Courts agree that hospitals have a duty to act reasonably in providing care and preventing injury to a patient.[45] The extent of the duty is based upon the

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42. The research for verdicts involved a national search of the LEXIS VERDICT and WESTLAW LPR-JV databases for all reported verdicts involving hospitals and restraints. The verdicts ranged in dates from 1980 to 1995. The verdict files do not provide legal analysis. These files simply contain a brief summary of the facts, arguments of the plaintiff and defense, and a verdict. While this research demonstrates that actions are brought against hospitals for injuries associated with restraints, the incidence level is extremely low in comparison to the total number of malpractice actions brought against hospitals. For example, the LEXIS VERDICT file contained 959 malpractice actions brought against hospitals in 1995 alone.

43. The opinions, in contrast to the verdicts, are reported and unreported cases providing complete legal analysis and conclusions of law.

44. "Failure to properly restrain" includes situations where no restraints were used and situations where the patient was not adequately restrained.

45. *See, e.g.*, Butler v. Caldwell Memorial Hosp., 412 P.2d 593, 595 (Idaho 1966) (noting that hospitals

circumstances of each case, including the patient's physical and mental condition and other external circumstances within the hospital's control.[46] A hospital's duty to protect a patient, however, is limited to those risks that are reasonably foreseeable under the circumstances.[47] While courts are in agreement that hospitals, and health care providers in general, owe a duty of care to their patients, courts differ on how to determine the applicable *standard of care* with respect to use of restraints in a hospital setting.

1. Ordinary Negligence Versus. Medical Malpractice

To determine the appropriate standard of care, courts approach restraint cases in one of two ways: either as ordinary negligence cases or as medical malpractice actions. The distinction between ordinary negligence and medical malpractice turns on whether the use of restraints is viewed as involving a "matter of medical science or art requiring special skills not ordinarily possessed by lay persons [*i.e.* medical malpractice] *or* whether the conduct complained of can instead be assessed on the basis of the common everyday experience of the trier of the facts [*i.e.* ordinary negligence]."[48] The court's determination on this issue affects the burden of proof, and the type of evidence that is admissible to establish the applicable standard of care. The consequences of this decision not only affect the outcome of a particular case, but may affect the ability of health care providers to change their approach to restraint use in the hospital setting based on the status of the common law.

In essence, the court's determination of the appropriate standard is based on its view of the "common knowledge" exception. Under the ordinary negligence view, courts look to the nature of the action itself, not to the "title

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have a duty to exercise reasonable care toward patients) (citing Hayhurst v. Boyd Hosp., 254 P.2d 528 (Idaho 1927)); Papa v. Brunswick Gen. Hosp., 517 N.Y.S.2d 762, 763 (N.Y. App. Div. 1987) (same); Alaggia v. North Shore Univ. Hosp., 459 N.Y.S.2d 96, 97 (N.Y. App. Div. 1983) ("[I]t is well established that hospitals have a duty to exercise reasonable care and diligence in safeguarding a patient."); Hilzendager v. Methodist Hosp., 596 S.W.2d 284, 286 (Tex. Ct. App. 1980) (same).

46. *See, e.g.*, Hunt v. Bogalusa Community Med. Ctr., 303 So. 2d 745, 747 (La. 1974) ("[I]t is the hospital's duty to protect a patient from dangers that may result from the patient's physical and mental incapacities as well as from external circumstances . . . within the hospital's control."); Robbins v. Jewish Hosp., 663 S.W.2d 341, 346 (Mo. Ct. App. 1983) (same); *Butler*, 412 P.2d at 595 (same); Ford v. Vanderbilt Univ., 289 S.W.2d 210, 214 (Tenn. Ct. App. 1955) (same); Cochran v. Harrison Memorial Hosp., 254 P.2d 752, 756 (Wash. 1953) (same).

47. *See, e.g.*, Dollins v. Hartford Accident & Indem. Co., 477 S.W.2d 179, 183 (Ark. 1972) (stating a hospital is not negligent for not guarding against circumstances that it cannot reasonably foresee); Hellerstein v. General Rose Memorial Hosp., 478 P.2d 713, 715 (Colo. Ct. App. 1970) (same); DeBlanc v. Southern Baptist Hosp., 207 So. 2d 868, 871 (La. Ct. App. 1968) ("[A] private hospital is not an insurer of a patient's safety, and the rules as to the care required are limited by the rule that no one is required to guard against or take measures to avert that which a reasonable person under the circumstances would not anticipate as likely to happen.") (quoting 41 C.J.S. *Hospitals* § 8c(3)); *Cochran*, 254 P.2d at 756 (same).

48. *Papa*, 517 N.Y.S.2d at 763-64 (emphasis added) (citations omitted); *see also* Graniger v. Methodist Hosp. Healthcare Sys., Inc., No. 02A01-9309-CV-00201, 1994 Tenn. App. LEXIS 513, at *8-11 (Tenn. Ct. App. Sept. 9, 1994) (discussing distinction between medical malpractice and ordinary negligence).

or the character of the party performing the act."[49] With respect to the use of restraints, many courts determine that the trier of fact is equally able to assess the need for restraints based on the circumstances of the case.[50] To determine if a health care provider breached its duty of care, the jury may consider factors such as the patient's age, physical and psychological characteristics, hospital staffing levels, or deviations from hospital rules and procedures.[51] These factors allow a jury to make a "common sense" determination as to whether the injury was reasonably foreseeable. Medical expert testimony under the ordinary negligence theory is persuasive but not controlling.[52] Thus, there is no burden on the plaintiff to establish a standard of care as part of their prima facie case; rather the plaintiff simply must put forth sufficient evidence such that a jury could reasonably conclude that the health care provider acted unreasonably under the circumstances.

The medical malpractice approach to restraints, however, views the "common knowledge" exception as applicable in only blatantly erroneous situations.[53] These courts view decisions regarding the use of restraints as beyond the purview of lay persons because factors such as the patient's age, particular medical ailment, and physical and psychological condition are an integral part of the overall treatment prescribed by the patient's health care providers.[54] Consequently, these courts *require* expert testimony in order to

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49. D'Antoni v. Sara Mayo Hosp., 144 So. 2d 643, 646 (La. Ct. App. 1962).

50. *See* Merrit v. Karcioglu, 668 So. 2d 469, 478 (La. Ct. App.), *writ granted in part*, 672 So. 2d 677 (La.), *and reconsideration denied*, 675 So. 2d 1063 (La. 1996) ("The jury is entitled to find liability when the 'alleged act is one from which a lay person can infer negligence based [on] common knowledge.'") (citation omitted); *Robbins*, 663 S.W.2d at 346 (same); Rhodes v. Moore, 398 P.2d 189, 191 (Or. 1965) (holding that it is within the knowledge of the jury to determine if guardrails were necessary); Hilzendager v. Methodist Hosp., 596 S.W.2d 284, 286 (Tex. Ct. App. 1980) ("We think the jury was entitled to conclude, without testimony of an expert, that the hospital's rule pertaining to side rails is in keeping with the conduct of a person of ordinary prudence under like circumstances, just as we think it would be unnecessary to offer proof that a hospital should not make its floors slippery.").

51. *See Merrit*, 668 So. 2d at 478 (considering patient's age, prior fall, state of confusion and patient's condition when physician evaluated patient's condition); Polonsky v. Union Hosp., 418 N.E.2d 620, 622 (Mass. App. Ct. 1981) (holding that deviation from hospital regulation is evidence of negligence); Dunn v. County of Robertson, slip op., (Tenn. Ct. App. Jan. 30, 1984) (holding jury may properly consider factors such as patient's "size, the fact that she was suffering from arteriosclerosis, her poor health generally, and the weakness on her right side resulting from the stroke"); Ford v. Vanderbilt Univ., 289 S.W.2d 210, 214 (Tenn. Ct. App. 1955) (considering patient's medication and previous falls).

52. *See Merrit*, 668 So. 2d at 477 ("Expert opinions are persuasive, but [they] are not controlling."); Burks v. Christ Hosp., 249 N.E.2d 829, 831-32 (Ohio 1969) ("Under such circumstances, expert opinion is not controlling as to what the rules, regulations, customs or standards of care are with regard to the application of side rails to a bed in a hospital.").

53. *See, e.g., Merrit*, 668 So. 2d at 483 (Klees, J., concurring) ("[E]xpert testimony is not required when negligence is obvious to a lay person, i.e., a sponge left in the body, a patient who bled to death. However, whether restraints should have been used on Mrs. Boutte (considering her fragile condition and age) is a critical issue that requires expert testimony absent which Dr. Karcioglu may not be negligent.") (citation omitted); Graniger v. Methodist Hosp. Healthcare Sys., Inc., No. 02A01-9309-CV-00201, 1994 Tenn. App. LEXIS 513, at *9-11 (Tenn. Ct. App. Sept. 9, 1994) (stating that the "common knowledge exception applies to cases in which the medical negligence is as blatant as a 'fly floating in a bowl of buttermilk' so that all mankind knows that such things are not done absent negligence").

54. *See, e.g.*, Smee v. Sisters of Charity Hosp., 620 N.Y.S.2d 685, 686 (N.Y. App. Div. 1994) (holding

establish the applicable standard of care for the health care community.[55] If expert testimony is not provided, these courts conclude that a jury is merely "speculating as to the type of care that [a patient] should expect."[56] Therefore, under the medical malpractice theory, the burden is on the plaintiff to establish *both* the appropriate standard through expert testimony and the defendant's breach of that standard in order to establish a prima facie case.[57]

A court's position regarding the standard of care has serious implications for health care providers who desire to alter the current practice for use of physical restraints. The ordinary negligence theory provides very limited predictability regarding how a trier of fact may view changing approaches to the use of restraints. Since expert health care professional testimony is not given any greater weight than other circumstantial evidence, the trier of fact is free to reach any decision it deems reasonable based on its own "common knowledge." Therefore, the trier of fact may or may not fully appreciate or be concerned with the policy goals behind the desire to reduce the use of restraints based on their own perceptions of what is appropriate.

The medical malpractice theory offers some benefit to health care providers over the ordinary negligence theory. First, this approach is "sensitive to the role of medical judgment in regulation of the use of restraints."[58] Second, the medical malpractice theory gives health care providers the opportunity to incorporate changing medical ideology through the use of expert testimony. Finally, expert testimony may prove to be a disincentive to smaller claimants based on the costs associated with obtaining medical experts.[59] Accordingly, this standard of care would encourage health care providers to embrace changing approaches to the use of restraints.

Unfortunately, there is no guarantee which approach a court will adopt in certain situations. In selecting the appropriate standard of care, some courts

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that the decision to leave patient in a chair unsupervised and unrestrained involves medical judgment based on patient's physical condition); Raus v. White Plains Hosp., 548 N.Y.S.2d 307, 308 (N.Y. App. Div. 1989) (holding that an action was based in medical malpractice since use of restraints is related to assessment of patient's condition); Wagner v. Fairview Gen. Hosp., No. 54168, 1988 Ohio App. LEXIS 3151, at *5-6 (Ohio Ct. App. Aug. 4, 1988) ("In light of decedent's heart condition, we are unable to say that most lay persons could assess the decision to refrain from ordering a posey in order to prevent thrombophlebitus [sic] based on their own experience and knowledge. We conclude that the decision was one strictly within the special and technical knowledge of the medical profession since it was not a matter of routine care.").

55. *See* Mossman v. Albany Med. Ctr. Hosp., 311 N.Y.S.2d 131, 133 (N.Y. App. Div. 1970) (affirming dismissal of action where plaintiff did not provide expert testimony with respect to the use of side rails); Cochran v. Harrison Memorial Hosp., 254 P.2d 752, 755 (Wash. 1953) (holding testimony regarding standard of medical care in the community was required for finding of negligence).

56. Starr v. Providence Hosp., 312 N.W.2d 152, 154 (Mich. Ct. App. 1981) (citation omitted).

57. *See, e.g., Mossman*, 311 N.Y.S.2d at 133 (holding plaintiff failed to meet burden of proof where plaintiff did not offer expert testimony regarding the standard of care with respect to side rails); *Cochran*, 254 P.2d at 756 (holding that plaintiff must establish the basis for reasonable care on the part of the hospital with respect to use of side rails).

58. *See* Johnson, *supra* note 24, at 268.

59. *See id.* (discussing the potential adverse impact on elderly plaintiffs of imposing requirements such as first filing malpractice actions with screening panels or tribunals).

make a distinction between the decision to *use* physical restraint and the failure to *adequately* restrain after the decision has been made to use restraints, finding the medical malpractice standard appropriate in the former but not in the latter context.[60] However, there are also cases which fail to make any distinction, concluding that restraints in general are within the "common knowledge" of the trier of fact.[61] Therefore, this particular aspect of the common law does not offer much assurance to health care providers in altering their use of restraints since the issue of the appropriate standard of care is far from settled.

2. Affirmative Defenses—Contributory Negligence and Assumption of Risk

The affirmative defenses of contributory negligence and assumption of risk may be useful to health care providers who desire to modify the current practice of restraint use. If the plaintiff's negligence is shown to have contributed to the plaintiff's injuries, the plaintiff will either be barred from recovery, or the recovery will be reduced in accordance with the plaintiff's degree of fault.[62] With assumption of risk, however, the defendant's negligence is not actionable because the plaintiff is said to have knowingly, competently, and voluntarily assumed the risk of injury.[63]

These defenses may assist health care providers in implementing changes to their current practice of restraint use because it protects them from unwarranted liability. For example, assume a health care provider properly implemented a restraint reduction program in a hospital by making certain modifications to the facility as well as establishing corresponding policies and procedures.[64] The physician, nursing staff, and administration could conceivably develop a patient or surrogate educational program whereby health care providers would explain to the patient-surrogate[65] party the restraint use philosophy of the hospital and its implications. By soliciting the patient's understanding and co-operation, the health care provider could conceptually share or shift the risk of injury to the patient.

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60. *See* Taylor v. City of Beardstown, 491 N.E.2d 803, 811 (Ill. App. Ct. 1986) (distinguishing between the medical decision to use restraints and failure to adequately restrain, supervise, and exercise care); White v. Sheehan Memorial Hosp., 500 N.Y.S.2d 885, 885 (N.Y. App. Div. 1986) (same); Wagner v. Fairview Gen. Hosp., No. 54168, 1988 Ohio App. LEXIS 3151, at *6 (Ohio Ct. App. Aug. 4, 1988) (same).

61. *See* Merrit v. Karcioglu, 668 So. 2d 469, 478 (La. Ct. App.), *writ granted in part*, 672 So. 2d 677 (La.), *and reconsideration denied*, 675 So. 2d 1063, 477 (La. 1996) (holding decision to restrain is within the common knowledge of a lay person). *But see* Smee v. Sisters of Charity Hosp., 620 N.Y.S.2d 685, 686 (N.Y. App. Div. 1994) (holding decision to leave patient in a chair unsupervised and unrestrained involves medical judgment based on patient's physical condition).

62. Jurisdictions that pro-rate the degree of damages adopt a comparative negligence standard instead of a contributory negligence standard.

63. *See, e.g.*, White v. United States, 780 F. 2d 97, 107 (D.C. Cir. 1986) (holding that a hospital must prove that plaintiff-patient had "full comprehension and appreciation" of the risk assumed).

64. *See supra* notes 36-39 and accompanying text.

65. Hereinafter "patient" is understood to include a "surrogate party" if the patient is incompetent.

While case law is limited on the issue of contributory and comparative negligence/assumption of risk regarding the use of restraints, a few cases support this theory. In these cases, the patients sustained injuries from falling and asserted that the hospital was negligent in failing to provide adequate restraint.[66] The courts concluded that the hospitals were not negligent because the patients, who were instructed not leave their beds without assistance, assumed the risk of injury when they moved from their beds without assistance.[67]

Other cases, however, hold that the patients did *not* assume the risk of injury because they were incapable of appreciating the risk.[68] Thus, patients should be informed about and be able to understand the risks associated with a reduced restraint program.[69] This approach, however, may be difficult in a hospital setting for various reasons. First, health care providers may not have adequate time to sufficiently educate patients about the risks involved. Further, patients' medical and physical conditions could change quickly thus altering their ability to appreciate the risks involved.[70] Thus, health care providers must ensure that patients are adequately informed upon admission and continue to appreciate the consequences of their decision throughout the hospital stay.

B. Suggested Legislative Action

The common law, through the medical malpractice standard, offers some assurances to health care providers that their actions in reducing the use

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66. *See, e.g.*, Marottoli v. Hospital of St. Raphael, No. 280860, 1992 Conn. Super. LEXIS 2809, at *4 (Conn. Super. Ct. Sept. 29, 1992) (holding that patient's injury caused by "his own premature attempt to leave his bed unassisted"); Noble v. Insurance Co. of N. Am., 248 So. 2d 12, 13-14 (La. Ct. App. 1971) (holding that patient's injury was caused by leaving her bed without supervision after having been instructed not to do so without calling for assistance); DeBlanc v. Southern Baptist Hosp., 207 So. 2d 868, 871 (La. Ct. App. 1968) (holding that patient assumed the risk of falling where patient left her bed without supervision after having been instructed not to do so without calling for assistance); Browne v. Nash Gen. Hosp., 309 S.E.2d 704, 705 (N.C. Ct. App. 1983) (holding hospital not negligent where patient requested that the side rails be left down); Polisso v. Saint Elizabeth Hosp., No. 74 C.A. 100, slip op. (Ohio Ct. App. Mar. 12, 1975) (same).

67. *See supra* note 66 for a discussion of cases dealing with assumption of risk.

68. *See* Keyworth v. Southern Baptist Hosp., 524 So. 2d 56, 61 (La. Ct. App. 1988) (holding patient not capable of understanding instruction not to leave bed without assistance); D'Antoni v. Sara Mayo Hosp., 144 So. 2d 643, 646 (La. Ct. App. 1962) ("Considering the plaintiff's age and her semi-lucid condition and the fact that she was under sedation the entire time she was in the hospital . . . we do not believe that her action in attempting to get out of bed . . . amounted to negligence on her part."); Howard v. Research Hosp. & Med. Ctr., Inc., 563 S.W.2d 111, 113-14 (Mo. Ct. App. 1978) (holding that patient's mental condition is relevant to finding of contributory negligence); Rhodes v. Moore, 398 P.2d 189, 190 (Or. 1965) (holding plaintiff not capable of understanding instruction to remain in bed due to "daze" caused by a morphine shot).

69. *See* White v. United States, 780 F.2d 97, 108 (D.C. Cir. 1986) ("[T]o be contributorily negligent, the Hospital must demonstrate that appellant was 'aware of or should have appreciated the risks involved.'").

70. *See* Merrit v. Karcioglu, 668 So. 2d 469, 478 (La. Ct. App.), *writ granted in part*, 672 So. 2d 677 (La.), *and reconsideration denied*, 675 So. 2d 1063, 477 (La. 1996) (noting patient's condition may have changed subsequent to doctor's evaluation); *Keyworth*, 524 So.2d at 61 (noting expert testimony that "there are times when people ignore instructions or forget, then convince themselves that the doctor meant something else").

of restraints in a hospital setting will be deemed appropriate. The use of legislation and regulations,[71] however, would greatly enhance health care providers' comfort in this area. Moreover, legislation could simultaneously protect patients' right to be free from restraint. Finally, legislation could provide health care providers with the necessary incentives to implement changes in the use of physical restraints in the hospital setting.

In drafting legislation pertaining to the use of physical restraints, the legislature should consider several features found in legislation regulating restraint use in the nursing home setting. First, the legislation should establish a presumption that a patient has a general right to be free from the use of restraints.[72] Restraints should only be used to protect a patient or others from injury, and the burden should be placed on the health care provider to justify the use of restraints.[73] The legislation should require a physician to prescribe the restraint and document the need for the restraint.[74] In emergency situations, approval for continued use of restraints should be obtained promptly after the emergency has passed.

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71. While many states regulate the use of restraints in nursing homes and mental hospitals, *see, e.g.*, ME. REV. STAT. ANN. tit. 34-B, § 3803 (West 1995) (mental institutions); OHIO REV. CODE ANN. § 3721.13(A)(13) (Anderson 1994) (nursing homes); no states currently have enacted legislation directed at general acute care hospitals. Hospitals, however, are subject to some regulatory requirements regarding restraints. For example, "hospitals . . . are required to report incidents involving medical devices and patient's death to the [Food and Drug Administration]." Kapp, *supra* note 12, at 5. But perhaps of most significance, are the standards established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for the use of restraints. The JCAHO "is an independent body that develops standards of quality in collaboration with health care professionals and others and stimulates health care organizations to meet or exceed the standards through accreditation and the teaching of quality improvement concepts." Robert Mordarski, *Medical Futility: Has Ending Life Support Become the Next "Pro-Choice/Right to Life" Debate?*, 41 CLEV. ST. L. REV. 751, 783 n.225 (1993). While accreditation by JCAHO is voluntary, it is important to many hospitals because JCAHO accreditation meets requirements for participation in the Medicare program. *See* Karen A. Butler, R.N., *Health Care Quality Revolution: Legal Landmines for Hospitals and the Rise of the Critical Pathway*, 58 ALB. L. REV. 843, 846 (1995). The JCAHO recently revised its standards for restraints in general acute care hospitals. JCAHO, *Accreditation Manual for Hospitals*, Standards TX.7.1-TX.7.1.3.3 (effective July 11, 1996) (*on file with the University of Dayton Law Review*). The revised standards require detailed policies and procedures; staff, patient, and family education programs; development of alternative prevention strategies and implementation programs. *Id.* These revisions should significantly influence health care providers approach to the use of restraints in hospitals.

72. *See, e.g.*, 42 U.S.C. § 1396r (c)(1)(A)(ii) (1994) (providing nursing home residents have a right to be free from "restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms"); N.Y. PUB. HEALTH LAW § 2803-c (3)(h) (McKinney 1993) (providing general right of nursing home patients to be free from physical or chemical restraints).

73. *See, e.g.*, 42 U.S.C. § 1396r (c)(1)(A)(ii). Section § 1396r (c)(1)(A)(ii) states in pertinent part:

> Restraints may only be imposed—
>
> (I) to ensure the physical safety of the resident or other residents, and
>
> (II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

74. *See, e.g.*, *id.*; ILL. ANN. STAT. ch. 210, para. 45/2-106(b) (Smith-Hurd Supp. 1996) (stating "no restraints or confinements shall be employed except as ordered by a physician who documents the need for such restraints or confinement"); N.Y. PUB. HEALTH LAW § 2803-c (3)(h) (requiring written authorization by a physician (except in emergency situations) setting forth the circumstances requiring the need to restrain a nursing home resident).

The health care provider should be encouraged to choose the least restrictive means available that will safely accomplish the goal.[75] The legislation should specify both the intervals for checking on a restrained patient and for reviewing the order for the restraint.[76] The restraint should be applied only by trained personnel who are familiar with the use of the particular device.[77] Hospitals should be required to adopt written policies and procedures regarding the use of restraints,[78] and they should be required to maintain monitoring functions to ensure compliance. Finally, the patients should be informed of the need, anticipated duration, potential risks associated with the use of the restraint, and any reasonable alternatives in order to obtain their informed decision regarding the use or non-use of restraints.[79]

Legislation to this effect would promote several important policy objectives. First, the patient's autonomy will be preserved by limiting the situations in which a patient will be restrained and by involving them in the decision making process. This may help reduce a patient's fear and discomfort as well as reassure family members that their relative is receiving the proper care. Second, regulation will help reduce the risks associated with the use of restraints.[80] Requiring written policies and procedures, monitoring compliance, and using trained personnel may help reduce the injuries that are frequently associated with the use of restraints.[81] Third, documentation requirements force health care providers to carefully examine their reasons for using restraints. Forcing health care providers to thoroughly evaluate their actions may reduce the "reflexive" desire to use restraints. Finally, legislation frequently provides the necessary incentive to health care providers to effectuate needed change. Legislation can provide financial incentives for compliance by threatening loss of certification and licenses.[82] Legislation also promotes awareness among health care providers that may dispel the traditional rationales underlying the continued use of restraints.[83]

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75. *See, e.g.*, ILL. ANN. STAT. ch. 210, para. 45/2-106(c) (providing "[a] restraint may be used only for specific periods, if it is the least restrictive means necessary").

76. *See, e.g.*, CAL. CODE REGS. tit. 22, § 72461(a) (1990) (requiring renewal of restraint order every twenty four hours).

77. *See, e.g.*, ILL. ANN. STAT. ch. 210, para. 45/2-106(d) (providing "[a] restraint may be applied only by a person trained in the application of the particular type of restraint").

78. *See* Kapp, *supra* note 12, at 5 (noting that hospitals accredited by JCAHO are required to adopt policies and procedures for the use of restraints).

79. *See, e.g.*, ILL. ANN. STAT. ch. 210, para. 45/2-106(e) (requiring the nursing home resident to be advised of his or her right to have a person or organization notified of the use of the restraint within twenty four hours); CAL. CODE REGS. tit. 22, § 73524(a)-(c) (1995) (requiring informed consent with respect to the use of physical restraints in intermediate care facilities).

80. *See supra* note 25-30 and accompanying text.

81. *See supra* notes 25-30 and accompanying text.

82. *See* Mion, *supra* note 5, at 425 (discussing failure to comply with regulatory requirements, such as those imposed by state agencies, Medicare and Medicaid, pose a potential risk of loss of certification or suspension of operating licensing).

83. *See* Kapp, *supra* note 12, at 4 (discussing the influence of OBRA and other federal and state

The legislature should also address the health care profession's fear of liability in this area. The legislation should specifically provide that the use of restraints is a "matter of medical science or art requiring specialized skills not ordinarily possessed by lay persons."[84] Such a standard will ensure that expert medical testimony is required to establish the standard of care. This provision would afford health care providers with greater comfort regarding a reduction in the use of restraints. Greater credence will be placed on the expert medical testimony than on the lay person's "common knowledge" regarding the appropriate use of restraints. Further, the patient's rights provision should also help alleviate the fear of liability for failure to restrain. Government and hospital regulations regarding the use of restraints would be admissible to establish the standard of care, thereby providing the trier of fact with further evidence of a public policy favoring patient autonomy.

IV. CONCLUSION

While research does not support the conclusion that restraints can be feasibly eliminated in all settings of hospital care, many health care professionals agree there is a need for an overall re-evaluation and reduction in the use of physical restraints in the hospital setting. To accomplish this goal, it is necessary to address health care providers' fears regarding any potential liability for failing to restrain a patient. While the common law offers some assurances on this point, it has not been sufficient to overcome the perceived fear of litigation. Accordingly, legislation should be drafted to address the dual purpose of providing assurances to health care providers and protecting patients' rights.

Beth A. Buchanan Staudenmaier

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regulations on the use of restraints in nursing homes); Wykle, *supra* note 17, at 3 (same).

84. *See supra* note 48 and accompanying text.