Weighing the Risks

Summer 1997

Mr. J., a 79 year old widower in the early stages of Alzheimer's disease, was admitted to the hospital following a mild heart attack. Mr. J. had been living with his daughter and son-in-law for three months and was becoming increasingly disoriented. During his hospital stay, Mr. J. was anxious and agitated. He repeatedly insisted that he was not sick and that he was going home to be with his wife. The nursing staff, concerned that Mr. J. might try to get out of bed by himself, suggested the use of a vest restraint. Mr. J.'s daughter became angry, saying that instead of tying her father down like an animal, the staff should keep an eye on him to make sure he did not try to get out of bed. She was confident that her father would not try to leave the hospital, and even if he did, he would not be able to because the bedrails were fully raised at all times. On the third night of his hospital stay, at 3:00 a.m., Mr. J. was found stuck between the mattress and the bedrail, his face pressed against the mattress. He had been asphyxiated. Efforts to resuscitate him were unsuccessful.

This case can be considered from the perspectives of individual ethics, institutional ethics, and societal ethics. Respond to the statements below using the following scale:

1. Mr. J.'s daughter had the right to refuse to consent to the use of the vest restraint for her father.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

2. The decision to use a restraint should be based on the healthcare professional's judgment of the situation; consent should not be necessary.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3. Mr. J.'s physician should have ordered the use of a chemical restraint to prevent the accident.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

4. The decision to use the restraint should have been Mr. J.'s, not his daughter's.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

5. It was Mr. J.'s daughter's responsibility to make sure that her father did not try to get out of bed.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

1. Staffing levels should be increased to allow for closer monitoring of patients who are at risk for falling or trying to get out of bed.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

2. The hospital should be held liable for Mr. J.'s death.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3. As a matter of policy, the hospital should attempt to immunize itself and its staff from liability if a patient does not agree to the use of a restraint.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

4. Healthcare professionals should spend more time addressing the circumstances that lead to the use of restraints.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

5. More clinical education is needed to educate staff about the hazards of bedrails use.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

1. Any institution which receives Medicare funding should be required to have beds proved safe for all patients.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

2. The FDA should issue standards for beds, rails, and mattresses.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3. More healthcare resources should be allocated to researching the risks and benefits of using bedrails as restraints.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

4. The standard use of bedrails as a restraint should be stopped until data are collected proving that the benefits outweigh the risk.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

5. The federal government should be involved in establishing regulations on the use of bedrails—similar to the regulations for airbags.
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5