THE USE OF PHYSICAL RESTRAINTS IN AN ACUTE CARE MEDICAL WARD

by

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The Use of Physical Restraints in

an Acute Care Medical Ward

Dedicated

to the Memory of

Martin Loose

1891 - 1973

University of California, San Francisco

School of Nursing

Abstract

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This ethnographic study, conducted in an acute care medical ward, identified practices related to restraining patients. The study's aim was to derive an understanding of the use of restraints. This involved investigation of the conditions under which patients became physically confined, why devices were kept in place, and what terminated their requirement.

The study was conducted on a 34-bed medical ward in a general public teaching hospital. The study sample included permanent nursing staff and patients in physical restraints. Data were collected through participant observation, brief interviews with nurses and patients, and observation of interactions with patients.

Results indicated that nurses were younger and had a shorter employment record than support staff. Day staff were employed for the longest period, while night nurses were more junior.

Total number of hospitalized days for patients in physical restraints was 496 days, 14.12 percent of the hospitalized days of the total patient population. The average length of time spent in restraints was 13 days for male and 11 days for female patients. The

Posey jacket was the most frequently used restraint. Limb and trunk restraints were classified according to the number of body parts confined. The reasons cited most often for initiating the application of restraints were preservation of treatments, conditions of altered mentation, and for the patients' safety. From the patients' vantage point, restraints were felt to be a punishment and made them feel anger, despair, or a sense of being reduced to the position of an infant. Nurses agreed that restraints were necessary and warranted by the patients' behaviors and conditions. The risk of a patient coming to harm reduced the use of physical restraints to a matter of inadvertence. Nurses believed that restraints prevented the patient from coming to harm, thereby converting this practice to one of caring or necessity.

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TABLE OF CONTENTS

LIST OF TABLES xi

LIST OF FIGURES xii

CHAPTER I

INTRODUCTION 1
Background of the Study 4
Significance of the Study 7
Research Questions Addressed in the Study 7
The Nursing Profession within the Context of Society 8
The Use of Physical Restraints within Nursing Practice 13
A Short History of the Use of Physical Restraints . . . 16
Contemporary Studies of Restraining Practices 20
Advocacy for Nonrestraining Practices 23
Issues on the Topic of Physically Restraining Patients 24
The Origins of Using Physical Restraints within the General Hospital Population 27
Legal Considerations Concerning the Use of Physical Restraints 29
Restraining Practices in the Care of Children 30

CHAPTER II

THE ROLE OF THE BODY 33
Social Contract in Nursing on How to Look After the Body 35
The Body as Nature Which Must Be Conquered 37
The Body as Object 40
The Social and Cultural Body 44
The Skilled Body 48
From the Cartesian to the Phenomenological Body 50
The Wisdom of the Body 60
A View of Personhood and Common Humanity 63
Impact of Notions of the Role of the Body on the Use of Restraints 64
Conclusion 66

CHAPTER III

METHODOLOGY 68
Research Approach 68
The Research Setting 71
Physical Setting 71
The Medical Staff 72
The Sample 75
Data Collection Methods 85
Human Subject Approval 86
Interpretation and Analysis 88
Consensual Validation 89
Observer Effect 89
Summary 90

CHAPTER IV

FINDINGS 91
Organization of the Work 91
Views Expressed about the Staff and Patients 92
Views Expressed by the Medical Director 93
Views of Medical Students, Interns, and Residents 94
Views Held by the Relief Nursing Staff 95
Work on the Ward 96
Work on the Day Shift: Report from the Night Nurse 96
Inventory of the Work or Time Management 97
Mastering the Workload under Conditions of Security 101
The Work of the Medical Staff 107
The Devaluing of Staff and Patients 111
Summary 115

CHAPTER V

DESCRIPTION OF RESTRAINTS 116
What are Physical Restraints 116
Verbal Restraints 119
Equipment and Modes of Treatment Which Confine Patients 121
A Description of What Constitutes Physical Restraint 127
Designation of the Severity of Restraints by the Number of Confined Body Parts 128

CHAPTER V (continued)

The Hospital's Policy in Regard to Restraints 135
Clinical Considerations and Patient Variables Perceived as Warranting Restraint 138
Use of Restraints for Investigational Purposes to Aid in Making a Diagnosis 140
Use of Restraints to Preserve the Treatment Modality 141
Prevention of the Environment that Leads to the Use of Restraints 144
Use of Restraints Due to Muscular Weakness and Malaise 148
Summary of Conditions Under Which Patients Come to be Placed in Restraints 150
The Necessary Conditions Which Kept a Patient in Restraints 151
Condition Which Terminated the Use of Restraint 162
Patient Behaviors and Reactions to Restraints 163
Summary 168

CHAPTER VI

DISCUSSION OF THE FINDINGS 170
Environmental Factors, Equipment, Supplies, and Shortages that Impact on the Use of Restraints . . . 171
Discussion of Present Findings vis-a-vis Other Reports on the Topic of Restraints 173
Demographic and Other Variables Impacting on the Use of Restraints 175
Gaining Admission as a Sign of Achievement Or As a Last Resort 182
Family and Friends as Patient Advocates 184
The Nursing Staff's Views on the Topic of Restraints 187
Summary 192

CHAPTER VII

DISCUSSION OF THE FINDINGS FROM THE PERSPECTIVE OF THE ROLE OF THE BODY 194
The Body as Territory for Health Care Professionals to Act Upon 194
The Erosion of Skilled Body Performance through the Use of Restraints 202
Summary 205
Ethical Issues of Rights and Justice in the Use of Restraints 206

CHAPTER VIII

IMPLICATIONS 212
The Changed Practice of Restraints, Then and Now . . . 216
The Next Step 220

BIBLIOGRAPHY 223

APPENDICES

A LIST OF PATIENTS' ADMITTING DIAGNOSES 241

B STAFF PROFILE 245

C PATIENT PROFILE 247

D GUIDE FOR INTERVIEW 250

E NURSING RESEARCH COMMITTEE 252

F CONSENT TO BE A RESEARCH SUBJECT 255

G EXPERIMENTAL SUBJECT'S BILL OF RIGHTS 257

H INFORMATION SHEET 260

I VERBAL CONSENT STATEMENT 262

J RECOMMENDED APPLICATION GUIDELINES 264

K NURSING POLICY 267

LIST OF TABLES

Table 1	Number of Nursing Staff by Employment Status and Program Type	77
Table 2	Nursing Staff by Employment Status, Shift Worked, Age, Length of Employment on Ward, and Height and Weight	79
Table 3	Selected Patient Characteristics	80
Table 4	Selected Patient Characteristics According to the Time of Data Collection	82
Table 5	Total Number of Patients in Restraints According to Number of Immobilized Parts of Body, Days of Use, and Percentage	83
Table 6	Type of Restraint on Study Sample According to Number of Immobilized Parts of Body and Length of Time of Confinement	84
Table 7	Equipment Limiting Mobility	122
Table 8	Classification of Restraints by Confined Body Parts	129
Table 9	Documented Reason for Initiating Restraints as Stated on Nurses' Notes	142

LIST OF FIGURES

Figure 1	One-Point Restraint	130
Figure 2	One-Point Restraint	130
Figure 3	Three-Point Restraints	131
Figure 4	Five-Point Restraints	132
Figure 5	Then - A Coercion Chair	217
Figure 6	Now - A Gerichair	217

CHAPTER I

INTRODUCTION

In the United States, individuality, independence, freedom of choice, vitality, self-determination, activity, and a healthy body are highly valued. However, professionals mandated to deliver health care to patients who appear to require physical restraints are at variance with the aforementioned philosophy. Could it be that the practice of physically preventing patients' mobility has become such an accepted and taken-for-granted part of nursing care that it no longer is perceived as a method of last resort? Or could it be that the existence of the problem presented by the use of restraints is denied because we do not know how to go about seeking some understanding? Could it be that we do not know what constitutes a "last resort", which warrants the application of restraints, in a situation? Or is it that, for health care professionals, the patient's living body has a separate meaning from the self once that patient is hospitalized?

Duden (1985) pointed out that the body carries the history of the lived experience and that fright, pain, and anger become embedded in the flesh. According to Heidegger, the meaning of one's Being is not divorced from real life because, insofar as one's existence is concerned, this question of meaning is constantly but implicitly being asked and answered, albeit nesciently (Dreyfus, 1984). Merleau-Ponty

(1962/1983) pointed out that "it is impossible to deduce the normal from the pathological", or vice versa, as "illness, like childhood . . . is a complete form of existence" (p. 107). However, little emphasis has been placed on the skilled practice, bodily experiences, and perceptions that influence the nurse/patient relationship within the context of a given environment. Studies on the topic of restraints have been predominantly surveys and questionnaires, which rendered the complexity of the nurse/patient relationship as an objective, decontextualized phenomenon for study. The reported studies have been predominantly within the area of mental health, and other patient populations have escaped notice regarding this practice. The purely empirical approach of the natural sciences for the study of human phenomena needs to be questioned, as the practice under study is highly dependent on the context and is relational in nature. A transactional perspective is one where one neither searches for determinant traits in the person nor for inescapable environmental forces, but rather for ways in which the particular environment mutually influences individuals and is constituted by them (Wrubel, Benner, & Lazarus, 1982). This perspective provides the approach which is germane to this study.

While the understanding of everyday practice is not readily available to the practitioner, it becomes recognizable as salient when pointed out. What constitutes a human being is a universal concept, but the view of the person as a

> bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively both against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures. (Geertz, 1979, p. 229)

This view of the human being as a bounded entity seems to be in the process of changing to one that perceives the human being as existing in a relation of reciprocity (Carper, 1978). Mitchell (1973) pointed out that there is growing evidence that the quality of interpersonal contacts has an influence on a person's becoming ill, coping with illness, and becoming well. However, only recently has the importance of the nurse as a crucial variable been rediscovered through the therapeutic touch movement, first described by Krieger (1975).

Thus the recovery of understanding, rather than a mode of knowledge, is at stake in this approach, and the understanding is actually a stance of being, which is a particularly important concept for the human sciences. Cassell (1975) pointed out that

> The organized pool of medical information, conception, and beliefs does not contain or is in conflict with the paradigm or structure in which the personal rests. Indeed, the paradigm of the personal is not even defined, whereas the medical paradigm is highly differentiated and systematically instilled into the physician throughout his training. (p. 1)

While the analytic mode of thinking which deals with the technical-scientific domain of the profession is well developed and robust, the personal is more privative and in dearth of legitimation, according to Cassell. The foregoing are relevant concerns for nursing.

The belief in a stable world of invariate objects and in the predictability of life is placed into question when a crisis such as an illness occurs. Sarano (1966) pointed out that certain sicknesses lend themselves better to the idea of sickness-as-sign while others can be perceived as sickness-as-encounter. However, whether sickness is a sign for the patient or a symptom for the physician, it is the nurse who creates the environment in the hospital where the scenario comes into action. How the sick person will accept his illness, indulge himself in

it, or fight against it will depend to a considerable degree on the attitudes and behaviors of those in contact with him.

The reduction of the person to a body-as-object may be seen as one of the recurrent temptations of nursing (Benner, 1984b), especially in the use of physical restraints. Nurses may well be prepared to provide for the body, which is the prevalent image of man. It is particularly troublesome when nurses consider mind and body as separate entities. This dualistic conception has led to the view that only matter is real (Frey, 1981). Nurses need to be grounded in a comprehensive view that fosters the perception of the person as a unique being.

How the values that nurses place on their services are interpreted by themselves and their patients, and how life and health are defined, are very dependent upon the prevalent view of man, which ultimately rests with the accepted role of the body. It will be one of the tasks of this study to flesh out the views that nurses, patients, and their relatives hold regarding the role of the body - the very views that ultimately permit the use of restraints.

Background of the Study

The nurse/patient relationship as a reciprocal transactional experience has received little emphasis. The aspects of the skilled practices and bodily experiences or perceptions that are involved and shape the relationship are particularly wanting. The nurse/patient relationship evolves within the cultural context with its values, rituals, intentions, skills, feelings, and expectations. It is assumed that a range of common meanings are embedded in the cultural practices which hold shared meanings and form the contextual background against

which all human behavior takes place and from which no one can be free. The practice of scientific decontextualization and objectification can be used in the study of people, but for the foregoing reasons the results will always be incomplete. Having grown up in a particular culture and language, both nurse and patient meet in the hospital with a host of taken-for-granted meanings. Humans, unlike inorganic matter, are self-interpreting and self-defining and therefore can be understood only through the interpretation of their interpretations (Rabinow & Sullivan, 1979; Taylor, 1979). The interpretive approach proceeds from the stance that

> A web of meaning constitutes human existence to such an extent that it cannot ever be meaningfully reduced to constitutively prior speech acts, dyadic relations, or any predefined elements. Intentionality and empathy are rather seen as dependent on the prior existence of the shared world of meaning within which the subjects of human discourse constitute themselves. (Rabinow & Sullivan, 1979, p. 5)

Heidegger (1962) pointed out that "man's substance is not spirit as a synthesis of soul and body, it is rather existence" (p. 153). It is in this sphere of mutual existence that the patient, his family, and the nurse meet. Benner and Wrubel (1982) made the claim that "Western culture traditionally places a premium on abstract reason. As a result, we understand theoretical knowledge better and value it more than knowledge gained through practice and experience" (p. 11). The fact that clinical practice is devalued in relation to medical theory may be the reason for the paucity of studies on the subject of physical restraint.

While O'Shea (1983) found that between 5 and 40 percent of adult patients were being restrained, the magnitude of restraining practices on a national level is not known. In response to an inquiry, Friedman

(1983) reported that none of the responding nurses advocated the use of restraints, but most considered them a necessary evil. Some nurses expressed their strong reservations about restraints, indicating that they should be used only in the most desperate circumstances, while others felt it kinder to restrain a patient than risk serious injury or interruption of crucial treatment. All respondents agreed that physical restraint should be applied for the sake of the patient and not as a substitute for inadequate availability of staff or for the convenience of the staff. From the reviewed studies, none of the reported programs where nonrestraint became a policy did any of the predicted dire consequences come to pass. Rather, patients were generally found to be greatly improved, while the staff developed more tact and perceived less benefit from the use of restraints.

While nursing literature holds an abundance of documentation on the hazards of immobility, restraining is usually not included under this caption. Henderson and Nite (1978) pointed out that "all forms of restraint or immobilization are psychologically distasteful to living organisms" and "physiologically harmful as well" (p. 149). Sorensen and Luckmann (1979) stated that forcing a confused patient or restraining him will add to his fear and aggressiveness, and the more upset the patient becomes, the more confused and defensive he will be (p. 175). The most blatant shortcomings with regard to the use or nonuse of physical restraints center around the lack of knowledge of the effects of such practices and of alternative approaches. The use of restraints is primarily a nursing issue because the request is frequently initiated by nurses. Although it is plausible that there are instances when the use of physical restraints is experienced as a positive aspect of care,

there are only rare and special instances where it seems to apply. Restraining will be perceived by most patients as punitive and damaging (Blackwell, 1979), even in the event of minimal cognitive functioning, or perhaps particularly so.

Significance of the Study

This study has potential significance in three areas. First, it will provide further understanding of how nurses are taking up their practice within the complex social environment of an acute care hospital setting. Second, it will enhance our understanding of the culturally-embedded dimensions of the nurse/patient relationship. Third, nursing, along with other human sciences which claim a holistic perspective, can benefit from research that examines human behavior within the social context. While common meanings, culturally based, are held by groups of people who are similarly situated (Heidegger, 1962), rapidly developing technology and interventions impact on nursing practice and the expectations patients and their family members hold. Health care workers cannot assume that common meanings have developed about the role of the patient within a hospital or about the appropriateness of their interventions. This study will examine transactions between health care providers, the patient, and his family in order to focus on the practice of physically restraining patients.

Research Questions Addressed in the Study

For what conditions or behaviors do patients become physically restrained?

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Who initiates the order for restraining and who terminates the treatment of immobilization?

What are the patient behaviors observed while the patient is tied down?

What nursing assistance is given to patients by the nursing staff while the patient is physically restrained?

What consequences result from the observed interactions and behaviors regarding the role of the body?

What inferences can be drawn about the perspectives of the body as a consequence of the technology employed in the context of care?

The Nursing Profession within the Context of Society

Human communities are organized, though not planned. People interact in terms of what they perceive to be congruent with themselves and their conception of others. "Shared understandings, fixed in custom and law, become conventional norms" (Kavanagh, 1983, p. 1). It has been well documented that, within any organization, an individual's success depends upon strong social systems and knowledge of informal relationships (Meisenhelder, 1982). While many turn-of-the-century accounts of and by nursing leaders portray a struggle for recognition of women as responsible and responsive members of society, a struggle against the pressure to conform to traditional roles in their personal and professional lives, nurses tend to be less aware of their own support needs, individually and collectively (Meisenhelder, 1982). The traditional image of the nurse as a female, lacking in initiative and intelligence, subservient to the medical hierarchy of authority, is the result of the nurse being viewed as a sexual target, the result of the

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practice of nursing being housed in bureaucratic institutions, and the result of a lack of public knowledge about activities involved in professional nursing practice (Aroskar, 1980).

Contemporary nursing leadership is attempting to change the discipline's traditional stereotype of invisibility and to create a new type of socialization to the profession. However, as far as the public is concerned, consumers are more interested in the nursing care rendered to patients, and nurses will have to look more systematically within their own discipline and at themselves to recognize what it is that the public perceives. Henderson (1980) advocated that it is basic nursing care that is essential to human welfare and promoted research that focuses on basic human needs and problems involved with helping people. Partridge (1978) equated a commitment to caring with a female value system, which she fears is disappearing in the nursing profession. It is of interest that

> Today's young staff nurses deplore what they perceive as lowered standards compared with their generation of student nurses, when it is obvious that the staff nurses of their student days in turn found them wanting in comparison with their own excellence, and that even that group of staff nurses was already perceived as decadent by my contemporaries. (Altschul, 1979, p. 132)

This author summed up her stance by indicating that, while the importance of studying nursing is acknowledged, "we may be on safer ground if we look at nurses" for we shall be unable to agree on what nursing is all about, but are likely to agree that we are all nurses (p. 134). Hence nursing is what nursing does or, more specifically, what nurses do. "Each nurse is an active and intimate part of nursing . . . the profession that she both learns and helps to create" (Curtin & Flaherty, 1982). Nursing is finding its roots in the commitment to the

nurse/patient relationship, which was emphasized as early as 1859 by Florence Nightingale. Since the care of people traditionally has been the domain of women, it has been subsumed as a given within the profession and only recently has been acknowledged as the core of the "major caring profession" (Leininger, 1978, 1980; McFarlane, 1976; University of California, San Francisco, 1983; Watson, 1979).

Thus, while the caring role must be preeminent in nursing, the science of helping is in a process of existential flux. Within the profession, we are reluctant to acknowledge the overlap of the caring functions of other health team members and practically display scotoma when considering the lay contribution to caring, denying that most nursing in society is still carried out within the family by nonprofessionals, by relatives and friends. While it is fashionable to speak of the health care team, the patient, as the pivotal reason for its existence, is frequently a silent member.

Henderson (1966) has contributed significantly to our understanding of the nature of nursing and its inherent acts of caring, with her statement that

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. (p. 15)

How is it, one may ask, that we find ourselves in positions where we are confronting dilemmas in carrying out our mandate to be in a helping relationship with our patients? Davis (1981) asked what sort of human environments we hope for at the end of our lives, and pointed out that patients' rights are grounded in the ethical principle of autonomy. But

it is specifically this autonomy which is threatened by serious illness and dependency upon others.

Thus while nursing has as its primary ideal to assist individuals, families, and communities to attain, regain, or maintain optimal levels of health autonomously, many professionals assume that the patient is so impaired in illness that decisions have to be made on his behalf (Gadow, 1980). Gadow pointed out that "the subjective activity of giving sense and meaning to one's experience is at least as important as the application of objective categories in trying to understand an experience" (p. 6). Nurses have always had the opportunity to realize potentials within their patients and become their "bridge to life" (Hilliard, 1976) or to add to the burden of suffering. There are always heartbreaks and failures, as well as triumphs, when one is privileged to be involved in the lives of other people and in attempting with all one's knowledge, skill, and heart to serve them (Curtin, 1981). Not everyone within the profession will be able to claim the level of understanding and commitment that enables one to declare that nursing is an "exquisite obsession" for them (Styles, 1982); for some it may be a mere game. While Benner (1984b) underscored the development of the expert nurse within the complexities of nursing practice, it is nothing less than excellence that is expected by us when we are consumers of health care. While such examples as cited by Benner are a balm and a ray of hope for nursing, they also emphasize the flip side of what is forfeited by practices which can hardly be classified as therapeutic. Burnside (1984) asked, "Are nurses taught to tie people down?" and Annas (1984) wanted to know where nursing and medical students were "schooled

in the martial arts of restraint, forced treatment, intimidation, and violence".

Hospitals are frequently perceived as unpleasant places to be (Roth, 1972) and are considered total institutions that manage all aspects of patient life (Goffman, 1961). Styles (1982) pointed out, however, that people come to hospitals primarily to receive nursing care. How then do we fulfill our mandate, we may ask?

Most definitions of nursing emphasize that it is an interpersonal activity that focuses on the understanding of the patient as an individual (Chapman, 1983). However, would it not be more apt to adopt a transactional perspective in which "one searches neither for determinant traits in the person, nor for inescapable forces in the environment, but for the ways individuals and their particular environments mutually influence one another" (Wrubel, Benner, & Lazarus, 1981, p. 64)? This perspective would yield a more flexible approach and open new possibilities rather than hamper nursing practice with the mistaken assumption that we know the norms which direct our interventions. The view that only wage earners and people in positions of power and control can determine the reality of situations for those who are dependent on them is of questionable validity, according to McLeod (1970). As McLeod states, there is not much wrong with the world of wage-earning adults except that they seem to use their power to dictate to those who are dependent on them on either extreme of the age continuum, or are otherwise incapacitated to look after their own interests.

In nursing practice, patients frequently are looked after as ahistorical beings aside from their medical or health history, and there

appears to be a reluctance to encounter the patient as a person, much to a mutual loss for both the patient and the nurse. It is one purpose of this study to track the practice of using physical restraints in the treatment of those who need care. The role of the body is addressed in the subsequent section, since it is crucial to understand this role in order to gain some comprehension of how the helping profession could perpetuate the use of restraints, a practice that from the patient's perspective is rarely appreciated as facilitating his attainment of independent or as "contributing to health or its recovery (or to a peaceful death)", as Henderson (1966, p. 15) stated in the mandate for nursing.

The Use of Physical Restraints within Nursing Practice

What then is so unique or so common about the use of physical restraints in nursing practice? Whence does this practice have its origins and why is it a problem at all? It seems, one would gather from the current literature, that physical restraints are no problem at all, as there are no reported studies from within the general hospital arena, or the available data are submerged in publications on patient abuse. Most of what is written does not distinguish between the application of physical restraints and being restrained, much as Susan Sontag (1978) does not distinguish experiencing illness from having a disease, in her book "Illness as a Metaphor", which mainly serves to illustrate the discrepancy in conceptualizing illness and treatment between the health professional and layman. A view presently held by some is that nursing's major contribution will be made "in the interface of the social and biological sciences on illness and health" (Gortner, 1980),

and that that constitutes nursing's reality. However, as Benner and Wrubel (1982) pointed out, "Western culture traditionally places a premium on abstract reasons. As a result, we understand theoretical knowledge better and value it more than knowledge gained through practice and experience" (p. 11). Thus, while the profession is being shaped, present day practices require reinterpretation to become part of the process. The question of whether one could interpret the paucity of studies on the subject of physical restraints as a nonissue for nursing comes to mind. But this seems to be clearly contradicted by the reports of nurses' reactions to restraining and isolating psychiatric patients (DiFabio, 1981) and from anecdotal accounts.

The use of physical restraint on patients has attained staggering proportions, if the claims of some authors are indeed representative of hospitalized patients in general. McLean, Shamian, Butcher, Parsons, Selcer, and Barrett (1982) reported that 10 percent of patients in general hospitals and 50 percent of the residents of specialized institutions are restrained in some form or another for variable periods of time. Among four hospitals in Baltimore where a patient classification system was used which provided for the reporting of restraint as a category, it was found that between 5 and 40 percent were restrained at any given time within those institutions (O'Shea, 1983). However, there was no ready explanation available as to the widely discrepant necessity for restraining or reporting between the four settings with a similar patient population.

In a survey conducted in a 400-bed community hospital, of the 279 patients 70 years or older whose functional abilities were assessed, 19 percent were found to be in either body or arm restraints or both

(Warshaw, Moore, Friedman, Currie, Kennie, Kane, & Mears, 1982). Newbern (1982, 1983) reported the results of 162 interviews of nurses and other health care providers regarding the incidence of patient abuse. Her findings showed that what she termed as "socially acceptable" abuse, that is, "under- or over-medication, improper use of restraints, invasion of territory without permission", occurs most frequently among female patients who are chronically ill or aggressive. While the recommendations of this investigation were to restore the locus of control to the patient and to promote self-care, from the clinician's perspective the issue is more complex, as patients are frequently unable to advocate on their own behalf.

In response to inquiries about whether restraints are really helpful or necessary, whether restraints do more harm than good, and how and when a patient should or should not be restrained, Friedman (1983) reported nurses' responses. While none of the nurses who responded advocated the use of restraints, most considered them a necessary evil. However, a number of nurses expressed "strong reservations about physically restraining patients in any but the most desperate circumstances" (p. 79). Others expressed their views that "it is kinder to restrain a patient than to risk serious injury or interruption of crucial treatment" (p. 88). While all respondents agreed that the use of physical restraint should be applied for the sake of the patient and not as a substitute for inadequate availability or for the convenience of the staff, the tolerance level for the danger that the patient might injure himself, another patient, or a staff member varied according to their own orientation.

Dewhurst (1970) pointed out that children, old people, and confused patients can be found restrained "for their own good" and described types of physical restraints which, according to him, "have recently appeared on the market in England" (p. 750). The author claimed that these devices have been designed for use in nursing the elderly, preventing patients with skin rashes from excessive scratching, and in the "care" of disturbed children, while there is "no evidence that any of them have as yet been introduced into mental hospitals" (p. 751). Dewhurst drew attention to the reintroduction in "open door" hospitals of several reprehensible methods of restraint and advocated an undisguised locked door as preferable to the illusion of freedom.

Curiously enough, on this continent, physical restraint seems to never have been abandoned as a method of intervention in the treatment of the mentally ill (Rosenblatt, 1984; Voineskos, 1976; Whaley & Ramirez, 1980). In tracing the origin of the practice, it is of interest to note that each society throughout history has defined in different ways that which was found to be outside the realm of acceptable parameters (Foucault, 1961; Illich, 1982).

A Short History of the Use of Physical Restraints

It was during the Enlightenment that social leaders came to question earlier solutions to all kinds of problems. It was Philippe Pinel who first insisted that insanity was a functional disturbance and who unshackled the insane at the Bicetre asylum in Paris in 1793 (Pinel, 1806). The animality in madness was seen as evidence that the mad person was not a sick person and could be mastered only by discipline and brutality (Wilson & Kneisl, 1983). Pinel's (1806) treatment of the

insane and outrage over the "barbarous provocations of idle and unfeeling visitors . . . and rude brutality of attendants" (Pinel, 1806, p. 67) is considered one of the milestones in psychiatric history.

Another significant figure for the history of psychiatry is associated with the Tuke family of York (Sessions, 1971). It was William Tuke III who put to the test his beliefs about treating mental affliction with kindliness and humane methods, thus flying in the face of contemporary medical opinion (Sessions, 1971, p. 60). William Tuke's grandson, Samuel, gave an account of "The Retreat of York" since its inception in 1796 (Tuke, 1813). Tuke's research led to the discovery of many cruelties in other hospitals, since he visited almost every asylum in Great Britain and some on the continent. The findings in turn led to a Parliamentary Inquiry which made detailed investigations for two years, from 1815 to 1817 (Sessions, 1971, p. 67). The Retreat achieved worldwide renown; however, it was Conolly who was credited for the total abolition of mechanical restraint, which was the logical conclusion of the pioneer work of the Tukes (Macalpine & Hunter, 1964).

Conolly never claimed to have originated nonrestraint and meticulously acknowledged his debt to Pinel, the Tukes, Charlesworth, and Gardiner Hill (Conolly, 1856). While Conolly had entered Hanwell, the largest lunatic asylum, in May of 1839 as their resident physician and had abolished the use of physical restraint by October of that year (Hunter & Macalpine, 1973), Gardiner Hill, as house surgeon at the Lincoln Asylum, was able to reduce the restraint hours from 20,423 per year in 1829 to none over a sixteen-month period, at the same time that the occupancy rate almost doubled (Hill, 1850). At the time, the practice of not restraining mentally ill patients was called "absurd,

speculative, peculative, the attempt of a theoretic visionary, a candidate of popular applause" (Hill, 1850, p. 355), a "wild scheme of a philanthropic visionary", and "a breaking of the sixth commandment" (Bromberg, 1954, p. 99).

The influence of the Tukes was especially strong in the United Stated because of the ties between the Quakers of the two countries. Thus Quakers who visited the York Retreat founded asylums on this continent based on the moral treatment of patients, whereas Pinel, Charlesworth, Hill, and Conolly were much more concerned about improving the scientific basis in the treatment of the mentally ill. However, the direct application of moral treatment with its nonrestraint and benign management of the insane "mind" was not reflected in the treatment given to insane paupers (Bromberg, 1954, p. 101).

Humane treatment spread because of the efforts of philanthropic and inspired citizens on both continents, even more than from the few leaders among the medical profession. The most effective of these lay persons was Dorothea Dix, who visited the Retreat several years before she started on a crusade to establish mental hospitals in the United States (Rosenblatt, 1984). Dix's story, which started after a visit to an East Cambridge jail in 1841 where she came upon a few lunatics among the criminals, set her upon a crusade in the service of human betterment, which covered a period of twenty-five years (Bromberg, 1954, p. 101). However, in spite of the reasonableness of the nonrestraint principle and the marked improvements in patients that could be demonstrated, the Association of Medical Superintendents of American Institutions for the Insane (which has become the American Psychiatric Association) decided from its inception in 1844 to uphold the use of

restraint when a resolution to that effect was passed (Bromberg, 1954, p. 100). As late as 1885, when Hack Tuke made an extensive survey of American and Canadian institutions, some of the superintendents and psychiatrists were stout defenders of mechanical restraint, including the crib-bed (Tuke, 1885).

Tuke reported his distress over the conditions he found prevailing in mental hospitals, especially the overcrowded rooms and the frequency with which he found the employment of mechanical restraints in some institutions. He found such treatment indefensible and in excess of what would be approved in England, especially in view of the fact that other places used no restraints whatsoever. From the figures he extracted from the compendium of the "Tenth Census of the United States, 1880", Tuke calculated that 40,992 patients were in asylums and that 2,242 (5.4%) were under some form of restraint, with another 1,444 restrained by personal attendants. Of the forty institutions Tuke visited, thirteen had practically abolished the use of mechanical restraints (Tuke, 1885).

Bannister and Moyer (1882) claimed that the debate on the topic of mechanical restraints was already voluminous, as they reported their findings of a projected survey of fifty mental institutions. Five of the institutions stated in their by-laws, "It is in most cases much better for one or two attendants to sit by a patient for some hours than to put on any restraining apparatus, though the latter may ultimately be necessary and even beneficial" (p. 473). These authors reported that the gradual disuse of restraints was accompanied by a great improvement in the conduct of the patients, while attendants developed more tact and perceived less benefit from the use of restraints. Bannister and Moyer

stated that incidences of the use of both restraints and seclusion was higher in America and that the management of the insane was behind that of other countries, especially Great Britain.

Contemporary Studies of Restraining Practices

The debate over whether or not to use seclusion and mechanical restraints has continued through the present century, and actions remain paradoxical (Voineskos, 1976). Guirguis and Durost (1978) surveyed 370 psychiatric facilities in Canada to examine the prevailing practices in the use of mechanical restraints in the management of disturbed or violent patients. The vast majority of facilities (76.4%) were found to use mechanical restraints, with the frequence of use most prevalent in psychiatric hospitals (p. 213). From their data it is not possible to correlate the frequency of use with the number of beds per facility or to compare it to Tuke's survey finding of 36.29 percent. However, the inventory of the type of restraint in use did not differ from Tuke's study. The majority of facilities were found to lack a policy regarding the restraining practice, although they cited the control of violent behavior as the main reason for the use of restraints (p. 214).

Moskovites (1984) spoke to the complex issue of managing patients whose behaviors are violent, destructive, or impulsive. There is surprisingly little systematic research to determine the precipitating factors that influence these methods of treatment. Moskovites found that the most frequent use of restraints occurred over the weekend, with physical attacks on the staff as the prime factor (p. 5). Women in this sample were found to be involved more often, while men were restrained for "escalating loss of control" (p. 6). The average number of hours in

restraint for those patients who had physically attacked staff or another patient was almost three times longer than the average of all precipitating factors, suggesting that it is difficult to draw a line between therapy and punishment, if one can draw such a line at all. The results of this study indicate that the four factors that most strongly influence the decision to restrain and the average length of time in restraint are the time of day, the day of the week, the precipitating behavior, and the sex of the patient.

Schwab and Lahmeyer (1979), in a six-month study on a general hospital psychiatric unit, reported a 36.6 percent incidence of restraint or seclusion among their patient sample, with a higher incidence during times when there was a higher patient census. Soloff (1978) reported a 12 percent incidence of the use of restraints in a sixteen-month study on a psychiatric unit in a teaching hospital. Violation of limits and disruptive behavior were most often cited as reasons for the use of restraints. Philips and Nasr (1983), in a randomly selected group of state psychiatric hospital patients, found that 51 percent had experienced seclusion or restraint at least once. The frequency of patient behavior leading to seclusion or restraint appeared to be directly related to the stimulation caused by the presence of many staff members and other patients. Notably, patients felt that violent actions were appropriate responses to their feelings of fear, anger, or frustration (p. 231). The authors found that a number of patients explicitly endorsed physical threat or attack as an appropriate way to deal with what was experienced by them as provocation.

In a prospectively designed study by Soloff and Turner (1983), over an eight-month period an incidence of 10.5 percent of patients requiring seclusion was found. From the literature reviewed, it appears that the frequency of use of either seclusion or restraint varied widely, from 4 percent (Wells, 1972) to 66 percent (Waseson & Carpenter, 1976), and that there is agreement in these studies about the clinical justification for their use, that is, as a last resort. Bell and Palmer (1983) made the observation that nonrestrained patients were twice as likely to return to the psychiatric emergency service than restrained patients after eighteen months, and they postulated that "the restrained patients found the experience uncomfortable and chose not to return to the hospital for service during a psychiatric emergency to avoid the possibility of being restrained again" (p. 984). Neither demographic characteristics nor other variables were consistent enough in the reported studies to allow the composition of a risk profile identifying patients who would become assaultive or exhibit uncontrollable behavior. To some extent, it is the health professional's tolerance of the patient's behavior and the staff's standards versus those held by the patient that come into conflict. Philips and Nasr (1983) challenged the commonly held misconception that mentally ill patients are prone to violence (p. 231). Staff-enforced limits are central to the issue of restraint and define a set of ultimately unacceptable behaviors within a given setting. Soloff (1978) asked the question of whether the defense of the milieu is a modern evil sustaining the practice of mechanical restraint.

Advocacy for Nonrestraining Practices

It was Conolly (1856) who stated that "restraint and neglect are synonymous. They are a substitute for the thousand attentions needed by a disturbed patient" (p. 53). Raskin (1958) wrote about Korsakov, the first psychiatrist, and about Bekker's hospital, the first institution in Russia where nonrestraint was tried successfully. Korsakov, who was familiar with the writings of William Tuke and Conolly, was convinced that it was a rational and humane method of treatment. He realized the patience and abilities of the physicians and attendants would be taxed, and he remarked, "the less restraint for the patient, the more restraint for the physician" (Raskin, 1958, p. 471).

An innovative approach to the abolition of restraining devices was recounted by Christman (1983). He asked the staff to assemble for a special event on the hospital grounds and requested them to bring their favorite mechanical restraint as price of admission. After the restraints were in a large pile, he poured kerosene over them and lit it. None of the dire predictions came to pass as a result of the nonrestraint that occurred because of the absence of the devices.

A seven-month study on nonrestraint was reported by Jacoby, Babikian, McLamb, and Hohlbein (1958). The whole program in this report was directed toward boosting the patient's ego and self-respect, which required greater availability of the doctor to the patients, as well as regular meetings with the staff to make them "feel the importance of their work" (p. 119). Patients who were constantly in restraint before were now able to be sent home on overnight visits, and discharge rates increased ninefold. Difficult patients transferred from other services usually quieted down within one to two days, and their destructiveness

diminished markedly. Without changes in medication for their epilepsy, patients had fewer seizures. No tube feedings were necessary although they were needed previously, and no double shifts were required since the program started, although such shifts were common before. Thus, with an emphasis on permissiveness and the philosophy that punishment had no place in the treatment of mentally ill patients, the authors reported how the 500 female patients in their sample - who were dispersed over twelve wards that previously averaged forty patients in restraints each day - could, without additional staff, be transformed into a therapeutic milieu. The conclusions by these authors support the findings of early reformers such as Pinel, Tuke, Hill, and Conolly, that physical restraint temporarily handles a difficult ward situation, but that the net result is to worsen the condition of the patient and may irreparably prevent the establishment of a therapeutic relationship, as long as the patient perceives the staff as jailers.

Issues on the Topic of Physically Restraining Patients

Thus while the topic of physical restraints and seclusion rooms remains an embarrassing reality in the management of acutely disturbed and disruptive patients in the psychiatric field (Soloff, 1979), it would appear that these concerns have no bearing on the treatment of the "soma" branch of the discipline. Katz, Weber, and Dodge (1981) estimated that the frequency with which some types of restraining devices are employed at any given time may range up to 10 percent in a general hospital patient population. However, no information was given to support their claim. Cubbin (1970) noted that it is the number of available staff rather than the patient's condition that determines when

a restraint device is used. A policy of nonrestraining was reported from the department of geriatric medicine within a general hospital and had not resulted in an increase in wandering, falls, or other anticipated crises (Banks, Cumming, Ferguson, Miller, Raber, & Stevenson, 1982). Katz, Weber, and Dodge (1981) reported that patients over the age of 70 years are eight times more likely to be restrained than the general population. There seems to be a common tendency to assume that the physical limitations and handicaps of older persons imply their total inadequacy (Cover, Rodrigues, & Solomon, 1977). Christman (1978) commented that one of the most startling revelations from studies of nurses at work is the inconsistency between what nurses say and what they do. While there is an abundance of documentation on the hazards of immobility, notably in the elderly, in none of the reviewed literature was the effect of restraining associated with rendering the patient susceptible to disuse syndrome. Most textbooks on nursing do not include a chapter on restraining patients, and those that do are primarily addressing pediatric practice, describing and illustrating the methods of how to render care for a child safely. Henderson and Nite (1978) pointed out that "all forms of restraint or immobilization are psychologically distasteful to living organisms" (p. 1450). Furthermore, they stated, "hypomobility is physiologically harmful as well" (p. 1449). The authors went on to say that every effort should be made to counteract the adverse responses of those subjected to immobilization.

Misik (1981) voiced her concern along with that of later authors, noting that the restrained person is totally dependent on others for his safety and care. The issue of restraining is particularly contentious

as "policies vary from one institution to another and one physician to another" (Sorensen & Luckmann, 1979, p. 175).

The most blatant shortcomings with regard to the use or nonuse of physical restraints centers around the lack of knowledge of the effects of such an intervention and alternative approaches that could be employed. None of the reviewed literature deals with the patient's experience of being restrained, although it has been pointed out that "the last hours [of a person's life] are all too often spent in restraints" (Benner, 1984b, p. 216).

Wilson (1976) asserted that psychiatric nurses have been among the first mental health professionals to acknowledge the limitations of the medical model and intrapsychic theories in guiding their practices (p. 165). The perspective that people act on the basis of the meanings things have for them, and that the meanings are derived out of a reciprocal interaction within the total environment, is slow to gain credence within nursing practice.

Covert, Rodrigues, and Solomon (1977) introduced their article by retelling one of Grimm's Fairy Tales, with some liberties in the translation: A peasant made his old father eat out of a small wooden trough, apart from the rest of the family. One day he found his little son fitting pieces of wood together. When questioned, the son said, "It's for you, father, when you get old." The grandfather was immediately reinstated to his place at the family table.

At a workshop that arose from growing concern about the widespread use of restraining as part of routine care, Cape (1979) pointed out that restraining devices are so widely accepted that no one questions their use on ethical or humanitarian grounds. He suggested that, rather than

concerning themselves with policy or standards, the participants' focus should be on the inhumanity of restraints; he also advised them to bear in mind that, unless we throw restraints away now, we may one day find ourselves in them. Blatt (1973) stated that to observe sorrow untouched is to cause it to continue, and he urged us to consider our legal or quasi-legal, sanctioned policies and practices that lead to and encourage the denial of human rights to human beings (p. 10).

Swift (1945) was a master of reversing physical dimensions. When Gulliver awoke in Lilliput he wrote:

> I attempted to rise, but was not able to stir: for, as I happened to lie on my back, I found my arms and legs were strongly fastened on each side to the ground; and my hair, which was long and thick, tied down in the same manner. I likewise felt several slender ligatures across my body, from my armpits to my thighs. I could only look upwards; the sun began to grow hot, and the light offended my eyes. I heard a confused noise about me, but in the posture I lay, could see nothing except the sky. (p. 6)

While Gulliver's story is read with amusement, it also parodies patients who are confined to a horizontal position and immobilized through the inability to voluntarily move their bodies due to restraining. However, whereas Gulliver had not lost his capacities and ability to free himself, patients are in that situation because they are sick and therefore unable to free themselves.

The Origins of Using Physical Restraints within the General Hospital Population

In an attempt to trace the practice of restraining the sick within the general hospital population, several sources have been consulted. Flood (1984) suggested that the practice probably came into being when separate hospitals for the wealthy and indigent were established and

nurses entered the latter with a reformatory zeal, originating from their belief that the patients lacked some character traits that had to be taught. M. Williams (1984) stated that probably only limited information is available and what there is is buried within certain historical accounts, which makes the information difficult to access. Tessler (1984) suggested that the practice probably came about with the establishment of hospital standards that delineated what is considered an appropriate environment for those in need of care. Brown (1983) felt that the practice had probably become acceptable when psychiatric units were introduced into general hospitals. Interestingly, Conolly (1847) observed that "the infirmaries had gradually become places in which restraint was more abused, and more frequently and repulsively employed" (p. 48).

Publications on patient abuse have continued to depict institutional settings from the vantage point of the specific professional. Gutheil (1980) pointed out that the judicial mind assumes that patients emit discrete measurable behaviors which require discrete measurable "emergency restraints". Sundram (1984) asserted that minor patient abuse is precluded by the very working conditions that contribute to its occurrence, and major abusive conduct is precluded by powerful administrative and disciplinary structures. In response, Gutheil (1984) stated that the morale of a unit and caring concern which is "transmitted directly from the top" have been overlooked.

Appelbaum and Roth (1984) refuted the assumption that psychiatrists are the only physicians to treat patients against their will. During eleven weeks on two medical wards, the authors noted eighteen episodes of involuntary treatment and restraint, which were usually employed when

the patients refused needed treatment and therefore were judged incompetent. However, the use of physical restraints is primarily a nursing issue because such intervention is frequently initiated at the request of nurses to provide for the safety of the patient.

Legal Considerations Concerning the Use of Physical Restraints

From a legal perspective, the basic rule is that "any nurse can apply as much restraint as is necessary to protect a patient from hurting himself" (Regan Report, 1983). Accordingly, one does not require a physician's order to apply restraints. Court cases have been reported as a result of accidental injuries when patients were restrained (Canadian Government, 1981, 1982). However, the two opposing legal implications between Canada and the United States do not seem to result in divergent practices (Brown, 1983).

Although the use of physical restraints for the ill is a gray area of practice, studies have demonstrated that rather than preventing accidents or injury, the restriction of people's movements have an adverse effect (Bronstein & Zalar, 1982; Canadian Government, 1981; Cape, 1979; Creighton, 1982; Kulikowski, 1979; Morse, Prowse, Morrow, & Federspiel, 1983). Mitchell-Pederson (1984) presented data which revealed the beneficial effects a change in policy to one of nonrestraint can have, confirming findings of other investigators (Jacobi, 1958; Joel, 1985; Ramirez, Bruce, & Whaley, 1981; Stegne, 1978).

The standards of care now required by court ruling include not only food, shelter, clothing, and medical attention, but an overall quality of life that provides dignity, pleasure, and maximum freedom for

individuals (Wortis, 1984). The apparent anachronism between what we profess and do will be addressed in a later chapter.

Restraining Practices in the Care of Children

While there is a paucity of reports that take the perspective of the restrainer and restrained in their geographical confinement into account, the literature abounds with materials concerning the care of children. Greenacre (1944) defined the term restraint in terms of the prevention of a free response (p. 204). The author addressed the complexity of restraining of children through physical means by binding the child's body or shutting him up, or through psychic channels by the use of threats, warnings, and prohibitions, whether it involves pain and sets up marked counter-reactions, the time of life at which it occurs in the infant's life, and whether a single part of the body is involved. The experimental work of Watson (1919) was so well publicized that it influenced the experiments on infants for decades. Watson had observed three types of emotional behavior responses in newborn babies which he thought corresponded to the later emotions of rage, love, and fear. Dennis (1940), in an effort to test Watson's theory, isolated a pair of twin girls five weeks old and attempted to rear them with a minimum amount of stimulation and practice. The experimenters were able to maintain quite rigid conditions for six months by maintaining an environment of complete indifference and emotional sterility. By the time the twins, who were brought up in separate rooms, were eight months old, they had finally more or less captivated their captors, although the experiment was continued until the twins were fourteen months old. The Dennis study, while chiefly interested in what he called

"autogenous" behavior of infants, could not confirm Watson's theory. The simple hampering of movement may first quiet the infant, and only intense and sudden restriction of motion, with deep constriction, jerking or binding, and an angry or tense attitude of the person applying the restraint, provoked negative responses.

The folk customs which lend themselves to study in connection with the problems of restraining evolved around the various forms of swaddling. Landauer and Whiting (1964), in a study of child-rearing practices of eighty different societies, found that the stress of the various customs of binding and constraining diverse body parts resulted in an increase of stature in their populace when compared to other societies. Mead (1954) refuted the hypothesis that an unusually long swaddling experience is a significant aspect of the educational process by which the human infant born and raised by members of a given culture becomes a member of that society. It was her view that a baby born anywhere is capable of becoming a representative of the culture in which he grows up. She pointed out that "the idea of swaddling is particularly horrifying to Americans, one of whose major commitments is to freedom of movement" (Mead, 1954, p. 405).

Mittelman (1954) and Levy (1944) claimed that transient restriction of mobility may lead to a mixture of rage and anxiety in infants, but "that sustained and recurrent restriction after the child has moved freely for some months leads to a severe state of anxiety and hostility and serious damage to the image of self, which always has a strong motor component" (p. 154). Blake (1969) spoke to the feelings of grief, rage, helplessness, fear of attack and bodily injury, abandonment, guilt, and despair of immobilized hospitalized youth. The question naturally comes

to mind: Are adults less vulnerable to such reactions while confined? While it is plausible that there are instances when physical restraints are experienced as a positive aspect of care, as observed by some, the literature only documents rare and special instances where that applies (Favell, McGimsey, Jones, & Cannon, 1981; Hamad, Isley, & Lowry, 1983). Bunch (1982) found repeated instances when psychiatric patients thanked the staff following an acute crisis when physical restraints were used. Schilder (1984) observed one patient who was extremely restless and agitated in wrist and ankle restraints. However, this patient never pulled against the restraints. After he had regained his freedom, he explained that the staff had no alternative as he had felt out of control and would have hurt himself otherwise. This patient, too, expressed his gratitude for the staff having taken such good care of him, preventing him from coming to harm. Seabrooks (1984) recounted the events of a patient with Alzheimer's disease, who would come to his wife before going to bed at night, holding his wrists together in his request to be placed in restraints to prevent him from wandering at night and frightening his spouse.

Nonetheless, restraining, however rudimentary, will be perceived as punitive by most patients and damaging to the ill patient's self-concept (Blackwell, 1979). The role of the body will be discussed in terms of what it is to have a body as the taken-for-granted vehicle of our being in this world.

CHAPTER II

THE ROLE OF THE BODY

The use of physical restraints in caring for people is a vexing and problematic action, and needs to be addressed. In pondering the issue, Benner (1983) has suggested that considering the role of the body may be a fruitful way of gaining some perspective and will open this nursing intervention for study. When the body is considered separate from the self and the mind, then only an "object" body is being restrained. However, if personhood is considered inseparable from the body and the body is viewed as knower, then restraint of the body as a person becomes less plausible.

As indicated in the previous chapter, the reviewed literature reveals some astonishing facts. Conolly (1847), the English physician who was one of the reformers of asylums, wrote: "Nothing is more entirely satisfactory than the extreme attention paid to the most helpless of the patients, the imbecile, the idiotic, the paralysed, and all who have fallen into the utmost weakness of mind and body" (p. 154). Elsewhere, Conolly (1860) spoke of the older arrangements for the mentally ill, then thought to be beyond recovery and beyond amendment:

> . . . the jest of physiology and the mere despair of treatment. If [the patient] was quiet, he was left to his fancies . . . if troublesome, he was chained. . . . The morning brought him no hope, the day no variety, the evening no amusements, the night no rest. Neither the mind nor the body were regarded. It is the virtue of modern treatment that

> all this is reversed. . . . In the survey which has been made of the daily order of a good asylum, we have seen that . . . from the hour of the patient's awakening to the hour of his retiring . . . everything that is done, however trifling, has for its object to secure his comfort and to promote his recovery. (p. 545)

The language and descriptions Conolly employed attest to his concern about the suffering of individuals, and as he relates the histories of many of his patients, the people come alive for the reader. The general effect of Conolly's altered arrangements on the health of the patients was the return of reason to minds long deprived of it. In his discussion, Conolly stressed the importance of treating the patient as a person of worth. While such persons may be disturbed and grievously afflicted, Conolly emphasized that they are not insensitive to the best and purest affections, and their distrust can be overcome by candor and concern. Conolly was convinced that these patients would give their whole hearts to those who cared for them in this manner. None of the more recent literature expresses anything akin to the warmth, concern, or sympathetic feelings demonstrated by Conolly, nor are there any descriptions depicting the patient's perspective or experience. The question is, do we know so much more than Conolly did regarding the human condition that we do not need to question our conduct vis-a-vis a fellow human being?

In this section I will argue that it matters how the body is thought of and how the profession has contracted with the public to provide care. Views of how the present understanding of the role of the body has evolved will be addressed. The discussion will focus on the body as object, taking a cultural perspective. I will show how the body has a way of knowing in skilled and habitual activities and has a wisdom of its own. Finally, the view will be advanced that a unity exists in

our common humanity and affects the impact physical restraining may have on any therapeutic relationship.

Social Contract in Nursing on How to Look After the Body

In our time health has become of vital concern. As a result, forces that contribute or detract from health are of compelling interest and are transforming the values that impact on a person's well-being. The emphasis is on the enhancement of those things that are of benefit to health and the prevention of those that are destructive. However, the nature of human action has changed because of the developed technology and the augmentation through these technologies, which are more than just extensions. Man as machine, with technological extensions, therefore seems to be a plausible perception in our time. However, nurses help those in need to regain or maintain their health or to reach an optimum level of functioning. As a profession we do not exclude segments of the population. For the public to trust a professional requires that the latter will act in their best interest and have the necessary knowledge to provide the service.

Curtin (1982) stated that "the nursing profession commits nurses to work to improve the quality of living of those who seek to receive their services" (p. 99). However, doing what is in the patient's best interest depends upon the attitude of the professional toward the patient, that is, it depends whether the patient is passively acted upon or viewed as an active participant in the care. The extent to which nurses are committed to alter the realities of the lives of patients and their families in order to improve the quality of those lives, it will be argued here, depends on how the body is understood. Often we lose

sight of the patient as a person when we shift our perspective to focus solely on the biological mechanisms involved in the care of injury or disease. On this basis it can be surmised that it matters very much how we in the profession define the body, just as it matters whether or not the restriction of bodily movement through the application of mechanical restraints can ever be labelled as therapeutic.

Heidegger (1962) pointed out that "man's substance is not spirit as a synthesis of soul and body, it is rather existence" (p. 153). It is in this sphere of existence that patient and nurse meet each other in their mutual humanity. Although nurses are skilled in determining how a patient shall live within a given care environment, they must also come to recognize that the patient has a central role in any decisions. The tolerance of what the limits of acceptable activities are within a clinical setting is dependent on the cultural, societal, professional, and institutional norms which serve as referential points. While several kinds of body were in existence in the past, "we align ourselves to the notion of a standardized three-dimensional-body map. We constantly visualize our anatomy, which literally means our dismemberment" (Duden, 1985, p. 5). The body derived through the process of description, measurement, and norms has transformed the illness of the patient to the facts of disease. By the same token, the requirement of suffering has been replaced by the ideal of an esthetic maintenance and body repair. Thus the shared agreement in our practices is ultimately dependent upon the way we have conceptualized the role of the body.

Common sense understanding of experience is the framework within which all inquiry must begin. What we must search for is an

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understanding of the everyday world of the clinical setting in which the patient and nurse encounter each other. While it seems self-evident that there is no separate self from a body, the notion that the body is not the self can lead to the view that the "object body" is the body submitted for care. The issue of the "lived-body" has not been adequately addressed in nursing because it has been taken for granted that everybody implicitly knew what it is that qualifies. With the mandate for nurses to provide "individualized nursing care", it is assumed that the clinical situation will be addressed in the proper manner. However, in view of the brevity of nurse/patient interactions and the paucity of background information regarding the patient's biography and habits, nurses may well deliver expert nursing care to the objectified body while denying the care necessary to maintain habitual or skilled body performance. The body carries the history of the lived experience; as Duden (1985c) pointed out, "fright, pain, and anger get stuck in the flesh".

The Body as Nature Which Must Be Conquered

According to Duden (1984), the belief that nature is chaotic and requires organization, ordering and categorizing is an all-pervasive and entrenched notion among the technological culture. The modern body is the product of sections of corpses which manufactured both the body submitted for care and the private body, which likewise has come to be perceived through a grid of anatomical mappings. This development of the modern view of the body is consistent with other aspects of human life of homo oeconomicus (Duden, 1985a, p. 8). The body came more and more to be seen as an expression of Macht (might, power), to be

subjugated, controlled, and mastered. The development of a political technology of the body was accomplished between the 16th and 18th centuries (Duden, 1985a, p. 13). Illich (1986) points out that the medical system cannot engender a body, even if it cares for one from conception to brain death. In every epoch, bodies exist only in context. They form the felt equivalent of an age, insofar as that age can be experienced by a specific group. In most periods, "women seem to have different kinds of bodies than men, serfs different from those of lords" (Illich, 1986, p. 7).

The now prevalent ideology of "health" was first conjured up as a construct in the late 18th century (Duden, 1985b, p. 1). Health as a goal for individual well-being hides the context of managing and objectification of a Volkskörper (body of the people/common humanity) from which it originated (Duden, 1985a, p. 24). By making health an expected right and entitlement, a seemingly unending list of pathologies are defined and diagnosed and, once identified, become objectionable and require treatment. This view has particular impact in a practice profession such as nursing. If knowledge, as defined by the social construction of reality, is the means by which a profession can function, no one individual would be able to comprehend or know enough if it were not for simultaneous developments across the diverse biological and human sciences. While such advances in the natural and human sciences have inestimable ramifications for the lives of people, the accumulated knowledge in and of itself will not be able to explain or predict life as individually lived. Yet it is exactly individual lives that are at the center of nursing's practice and that we attempt to address through research and education.

Duden pointed out that the split between nature or the body and the social world has important consequences, since disciplines do not approach the body as a natural subjective given. For example, medicine starts as a history of ideas that are not seen as embedded in real life and are stripped from their surroundings, resulting in a vertical tunnel view over time, overlooking the horizontal perspective and the way in which the connections have developed. The derived categories are misleading as they only hint at something "pure", where health is something separate from disease, void of meaning but carrying consequences, just as the abstracted language of science stands for something that can never be, the meanings of ordinary life (Illich, 1984). While the difference between the language of the sciences and everyday life is often compared to a bilingual existence, Illich pointed out that such a comparison fosters a mistake. Unlike scientific language, spoken languages "all are meaningful in everyday sensual life for those who speak them. They alone, in a strict sense, deserve to be called 'languages'" (Illich, 1984, p. 14). The special scientific codes that have come into the repertoire of everyday vocabulary generate something akin to pollution by simply generating noise in conversations, which Illich compared to the dull expanses of concrete that economic growth has produced. The language whereby we attempt to make sense of the world can become like endless talk about talk, or like an intellectual game having little to do with the realities of nature.

It is through the agreed-upon sphere of language and concepts that the boundaries of the nursing profession are defined. The body, however, appears to be a place of wordless experience. Between the anonymous feelings generated by the body and the subject is the

difficult barrier of language. While information from the body may reach an intuitive, symbolic level, it may not be expressible in words. However, it is precisely the total human being, including the body, that is the domain of nursing. Only when we have defined what the reality of this domain is can we establish ranges and norms of what falls within agreed-upon parameters. Only then can we decide how much ambiguity the situation will tolerate. The following section is a case in point of how the body can be objectified.

The Body as Object

Gadow (1980a) pointed out that the "patient's self-interest cannot be professionally defined" and a "definition of a patient's self-interest made by anyone other than that patient is not only unethical, but in fact is impossible" (p. 1). However, the concept of self appears as elusive as that of health. Gadow (1980b) suggested four levels of relation between the self and the body. She described a progressive dialogue from the first level - the primary immediacy, to the second level - the disrupted immediacy, to the third level as cultivated immediacy - the harmony of lived body and object body, and finally the fourth level - aesthetic immediacy, which she saw exemplified in aging and illness (p. 172). In the first sense, "the relation between the self and body is immediate [and] has a unity whereby the lived body is not an instrument but is one's 'acting'. However, when the lived body becomes conscious of ineptness [through] weakness [or] pain phenomena arising from within itself" (p. 174), the disrupted immediacy can result in a new relationship between the self and the body. Gadow showed, following Hegel's dialectic, how a

master-slave relationship between the self and the body can develop, whereby the self as free subjectivity uses the body as a mere vehicle or instrument, or the reverse, where the body refuses to function and "the former master - the self - becomes the slave" (p. 175). In this disrupted immediacy, the relationship between the body and self is seen as a continual struggle, and once it has become problematic it can take two forms. One is the abstraction from the ambiguities of the subjective, producing "the theoretical object body of the sciences, which belongs unambiguously to the world" (Gadow, 1980b, p. 176). The other mode is to cultivate a view that accepts the body as "part of the world as well as part of the self . . . [and attempts to recover] the concrete unity of self and body" (Gadow, 1980, p. 176). Gadow depicted this cultivated harmony of the lived body and object body as the third level, where body and self are experienced in mutuality, which is achieved through a "struggle at the previous level" (p. 177). She saw this new unit as "the effortless exercise of a skill" by which a "new naturalness" is achieved, "one not given but created" (p. 177). The final level of an aesthetic immediacy, where the body is seen as subject, Gadow saw as being exemplified during aging and illness. Gadow did not deny the possibility of reaching the previous three levels of relating at any time during the lifespan, except perhaps in infancy.

While the mastery of the body is essential for the development of the self-body unity, it is inadequate as the sole basis for that unity (p. 179). Gadow claimed that the one-sided "concern for only the object body" misses "the body as a being in its own right" (p. 180). "The subject body, which may emerge in illness and aging", she depicted as not a "precondition of the self, nor is it sheer material for the

expression of the self; it is part of the self" (p. 180). Through this refined stance, the subject body no longer is involved in either the mastery of the body over the self, nor the self over the body, and "the self recognizes the body as another manifestation of selfness" (p. 181), which is not acknowledged until one is aging. It is particularly puzzling, when we finally seem to comprehend the linear progressive achievement, that Gadow stated "the subject body is no more justified in dictating its values to the rest of the self" (p. 181). She depicted the process as requiring mutual learning and used the development of children as an analogy. The subject body lastly reaches the status of an "aesthetic object" (p. 182).

Gadow attempted to elevate illness as an essential part of human existence, whereby the self-body unity can rise to a higher sphere of being. The suggestion that a person can derive harmony only through cognitively coming to terms with a body and self by aspiring to an elevated stance does not find concurrence with humanity at large. To consider Gadow's dialogue as an individual endeavor misses the social context within which a person finds reciprocity and affirmation. Life is not a once-and-for-all achievement and has to be lived in order to be experienced. The notion that a person has to suffer and be cognitively aware to be able to progress to a refined level of existence, and the suggestion that the disruption of the integrity of the self is necessary to achieve harmony, is particularly fraught with pitfalls for nursing. According to Gadow, nurses will care "for the part of the self that the individual values most", making contingencies for life-threatening events where the professional judgment justifiably can substitute for patient self-determination. While such an admonition is philosophically

sound and can be fully endorsed, the implementation of a self-agency on the patient's part needs to be questioned. Inherent in such abstraction of life as it is enacted in everyday existence is the temptation that the "self" and aesthetic subjectivity can become measurable dimensions.

Bonham and Cheney (1983) have indeed offered a model for assessing the concept of self. Although admitting to the difficulty of such assessment, these authors nevertheless claimed that through a systems approach "a two-dimensional process that includes the real self as well as the perceived self" (p. 179) can be attained. The authors described man as a living system which, left to its own devices, will become disorganized and, "if left unchecked, will lead to deterioration and death" (p. 179). With this view, the replacement of energy becomes a necessity, and a balance, once achieved, is taken as a sign of wellness. An unstable state becomes a sign of illness, and nursing must therefore "counteract the negative forces by utilizing positive forces or strength" (p. 180). With this perception of life as a balance sheet, the person can cope with any situation given that he/she has acquired the appropriate skill, which nursing is willing to provide. The authors claimed that through the assessment of the "self-image, self-esteem, and self-in-action", a representation of the real self as well as the perceived self can be found (p. 188), which would permit the impact of illness and disease on the self-concept to be measured.

Gadow (1980b) and Bonham and Cheney (1983) have abstracted the role of the body into a cognitive depiction that leaves out the context which both defines and constitutes the self. Furthermore, the body as knower is overlooked. While Gadow's dialectic between the body and self rests on the assumption of an ideal that can be reached by earning it through

suffering, Bonham and Cheney's model strives for control and power. Both approaches are attempts to address dimensions felt to be missing in the profession, but fail to focus on what the patient would find of benefit. The clarity and representation necessary to implement both models would require a mind separate from a body. The body accordingly must be dominated, mastered, and controlled, which attests to a perception where the body as nature is alien to us and the Cartesian mind/body split is perpetuated.

The Social and Cultural Body

To recapitulate the foregoing discourse, the view that nature is chaotic and in need of organization is a social construction. The late technological self-understanding is that the self, too, is raw material, chaotic, to be shaped, mastered, and controlled. As Phenix (1964) pointed out, however,

> Society and culture are by no means perfect. Nor are human beings necessarily responsive to whatever beneficent influences are brought to bear on them. People both resist and deny meanings and seek and affirm them, and cultures both destroy meanings and create them. Moreover, quite apart from individual or social threats to meaning, the perfection of human life is limited by the finitude of human existence. (p. 30)

Implicit in Phenix's view is the assumption that there is an ideal toward which each person strives that is derived from cultural and societal norms and practices.

Douglas (1973), an anthropologist, claimed that controls exerted by the social system place limits on the use of the body as a medium of expression. She stated,

> The social body constrains the way the physical body is perceived. The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual exchange of meanings between the two kinds of bodily experiences, so that each reinforces the categories of the other. As a result of this interaction the body itself is a highly restricted medium of expression. (p. 93)

While Parker (1981) took the above passage as "an explanation of the manner in which the biologistic medicalized model of the body advanced by Western society constrains the expression of the lived body of human experience" (p. 84), a transactional perspective will be suggested that is worthy of investigation. The singular quality of human life is a product of deliberate nurture. It is not a gift of nature; it is a creation of culture. This is another way of saying that meaningful human life is necessarily social.

Blacking (1977) argued that the basic premise of an anthropology of the body is that the mind cannot be separated from the body. He stated that the link between mind and body is made by nonverbal modes of communication, especially through dance and music. The fact that the dichotomy between the mind and body is expressed symbolically by the separate functions of the left and right hemispheres of the brain led Blacking to postulate that one hemisphere tends to be valued over the other, but that a complete human consciousness should include both modes of thought. Duden (1985) would argue that such a view lends support to her depiction of a social construction of the body, which impoverishes the richness of the lived experience. The way in which information received and processed at a semantic level becomes transduced into information at the bodily level is not understood.

It seems a curious development of our present time that people would need to be taught how to love and live and die. Fletcher (1973)

claimed that the reason we would need a description and list of criteria for humanhood is because of the discrediting of the classical "doctrines of man" by the biological and behavioral sciences (p. 93). The designation of a "human vegetable" and establishment of a hierarchy according to neocortical functioning is a development of the last decades. Straus (1956) pointed out that the questions addressed by investigators at any given epoch are those determined by our history, pre-thought and pre-spoken through the language of our times. The questions determine what seems pertinent and of note. However, many of the derived answers may attempt to order themselves under a system of objective validity. Through our questions, particularly those not made explicit, we remain tied to our traditions and prejudices. However, nobody is at the beginning because, as soon as we think, we perpetuate thoughts of our predecessors (p. 2). Straus claimed that psychology has accepted the Cartesian philosophy, which divides existence into two final states, one res extensa and one res cogitans, without critically evaluating the evidence for such a claim (p. 3).

Straus states that Descartes perceived the human body to be a machine and described reflexes that travel from periphery to the brain and back to the periphery, which Pavlov later experimentally exalted. However, for Descartes, the existence of a soul was never in question and was independent of the body, which is a machine and nothing more (p. 7). Thus Descartes, by dividing substance into body and soul, achieved the separation of spirit and world, which has remained a metaphysical puzzle. Straus questioned what it is that is addressed in studies of man's perceptions if the subject is not a living person who, after all, is the basis and rationale for such inquiry. It is the human

being who thinks, not the brain. Yet, according to Straus, some will maintain that the phenomena of behavior and mind are ultimately describable in the concepts of mathematical and physical sciences (pp. 112-113).

In Descartes' dichotomy, thinking was ascribed to the res cogitans and movement to the res extensa, which separated bodily motion and the experiencing of it. In spite of criticism of this position, the Cartesian influence has persisted to the present. The questions of motility have been delegated to the disciplines of physics and physiology, in spite of the fact that the necessity of a human, living, moving body is necessarily a prerequisite for experiencing the world and for providing scientific explanations (Straus, 1956, p. 290).

Heidegger made the point that the way we have learned to behave also applies to the way we perceive, "which also requires background skills and shared discriminations" (Dreyfus, 1984b, p. 20). Only when the ongoing activity ceases can reflective thought take place. Whatever is beyond the scope of language to convey remains within the realm of subjectivity, or as background, unless it becomes a dimension of concern. Neither subjectivity nor meaningless objectivity advances our understanding of the issues at stake. Merleau-Ponty, Dreyfus, and Benner have undertaken to transcend the subjective and objective categories in the lived experience, where the ambiguities are given a chance to enlarge the area of meaning.

To Merleau-Ponty (1962/1981), meaning and lack of meaning are matters of transition and degree.

> One cannot say that everything has sense or that nothing has sense, but only that there is sense. . . . A truth against the background of absurdity, an absurdity which the teleology of consciousness presumes to be able to convert into truth, this is the primary phenomenon. (p. 342)

Dreyfus (1984b) pointed out that both Heidegger and Merleau-Ponty "prefer to speak of the way that the whole human being is related to the world" rather than of the way that the world is apprehended by a mind. What counts as real is provided by the social context, social practices, and each person's own embodied understanding, which is congruent with the shared public world (pp. 3-4). To Merleau-Ponty, what is real is only part rational and what is rational only part real. Existence does not mean reducing behavior to a mere phenomenon of consciousness.

The Skilled Body

When a person is completely absorbed in an activity that is rhythmic and repetitive and has become so skilled at the task that the activity can be performed without attending to it, linear time as we are accustomed to measure it ceases to flow. This total involvement and absorption of the body and senses has been reported from experiences by athletes when, in the excitement of a game, the perception, coordination, and sense of time dramatically change. Time can slow down, and the total constellation of the game is seen as in a slow-motion picture, frame by frame, yet at the same time there is a full awareness of the speed with which the game progresses and how the appropriate moves are made (Dossey, 1982, p. 170). "In this state, perfection in perception and execution for the athlete are less a matter of doing and more a matter of being" (p. 172). The body has taken over automatically without conscious thought of what it is that has to be done. At the same time, however, the experience is one of the "extraordinary", which in this culture is called paranormal or mystical (Dossey, 1982).

Dreyfus (1984a), in a dialogue with Searle and a group of scholars and students, attempted to address the necessary existence of the body in skilled performance through which the human experiences existence, when he claimed that one could play tennis, if one were skilled in the activity, "without being there". An Olympic gold medalist in gymnastics (McTaggert, 1984) expressed essentially the same idea when he was asked what strategies he used and what was going through his mind before a routine, and he replied that he only worried about the first movement and then his body took over. Thus, while the human body is passive as mere res extensa, without intelligence or power of self-movement in Descartes' view, the body seems to have developed a mind of its own.

Leder (1984) pointed out that intelligence or the power of self-movement were ascribed to the mind, res cogitans, and were seen by Descartes as the essence of self and the divine aspect of the human being (p. 29). Thus the human body seen as a machine became assessable and susceptible to mathematical analysis and could be divided into organs, cells, and parts that could be repaired, removed, replaced, or technologically supplemented in relative isolation. In the acceptance of such views there are no restrictions against invasive treatment and ethical prohibitions become as outmoded as those which prohibit anatomical dissection (p. 30). Leder went on to point out that both Straus and Merleau-Ponty grounded their initial work in critique of the Cartesian model of the body and mind, and he revealed the influence this has on current psychology (p. 31).

To say the least, it seems incongruous that the body should be problematic, since each of us knows that we have one. Usually the question of having a body does not occur to the person and only becomes

an object for him when it is examined or sick. Jonathan Miller - physician, playwright, producer - in connection with a television series for the British Broadcasting Corporation entitled "The Body in Question", interviewed the British public regarding their knowledge of the location of their various organs, their function, and their purpose. Apart from the location of the brain, which seemed to be well-housed in the cranium, other organs developed dimensions and locations within the torso that would be most startling to health care professionals. Miller, in his series of programs, traced the development of knowledge regarding the body from antiquity to the present, but also sensitively portrayed the mystery of life and our inability to delineate the purposes of life scientifically, showing that the public does not seem to have such qualms. In other words, people manage to live their lives without requiring scientific definitions for its purpose.

From the Cartesian to the Phenomenological Body

Eckstein (1970) has traced the advances of our understanding of man and his body in great detail, including biographical sketches of the researchers, to reveal their perspectives. He showed that without emotion there is nothing that could be called mind; emotion is the clarifying beat of the mind and the mind, according to the physiologist, is imperative for the ultimate perfecting of the body's movement (p. 663). "Pavlov had his opinions. He had his convictions. He had his vehemence. He had his passion for work. He had his scientific imagination. And he kept something of the child" (p. 593). Pavlov believed that the conditioned reflex, his idea and his method, was applicable at every level of nervous activity, and had anyone doubted

that the mind was such a level, doubted that it belonged in the physiologist's domain, he would have blasted him with scorn (p. 596). While Einstein was saying that a phenomenon - a mind - was time and space, mass and energy or spirit, or there was nothing, for Pavlov existence was flesh, a satisfied monism, with everything (eventually) measurable with a yardstick. Eckstein noted, "in his research [Pavlov] ruthlessly ruled out the emotional, as he did the reporting of it" (p. 596), and fined his laboratory staff if they dared to let slip a phrase suggesting that the dog suffered, had a memory, or dreamed (p. 592).

Following Pavlov, persons with experimental talent have been capable of producing neurosis for half a century "in dogs first and later in a variety of animals, goats, fish, spiders" (Eckstein, 1970), p. 665). After "producing animals with severe neurotic problems, mind-sick, body-sick animals", Pavlov found ways of treating them (p. 673). Yet, while dog and man have similar pain receptors and pain paths, what happens along the termination of those paths, if that is where it happens, is not the same. Man's mind attaches meaning to the sensations, dwells on meanings, and embroiders sensations, which makes the ordinary sensation into something extraordinary in the mind (p. 701).

Phantom limbs have presented baffling mind/body problems. The phantom and limb again put mind and body in juxtaposition. A limb has been removed but has stayed in the mind. Plügge (1970) pointed out that the phantom limb has become the favorite topic in the domain of body-image disturbances. It was Henry Head who first coined the word "schema", which he understood to be a priori the first tactile or

kinesthetic experience. For Head, as stated by Plügge, the body schema had nothing in common with psychophysiological data nor with philosophy nor psychology. He was certain that the image was a potential that was given to the knowing and acting human being very early in life, possibly from the very beginning. Posture or passive movement rise into consciousness as a measured postural change, which is the basis for a standard against which all subsequent changes of posture are measured before they enter consciousness. Head's conclusions that the steady tactile and kinesthetic sensations lead to cortical and subcortical representational centers have been doubted or refuted (Plügge, 1970, pp. 8-9). Sacks (1984) explained that the "old" neurology of Head "was a science of neural mechanisms and function and, as such, descriptive and analytic but not too therapeutic" (p. 211). However, in Head's presence, neurology was enlivened by his charm and warmth, but without him was left "a cold and repellent puppetology" and a neurology that became a cold science (Sacks, 1984, p. 210).

Many scientists followed Head's work and embroidered on the image of a representational body. Schilder (1935) depicted the body schema as a tridimensional image that everybody has of himself, although he claimed it is not mere representation (p. 11). Later he seemed to have tempered his daring vision, but it only increased the confusion when he spoke of "the image and appearance of the human body", which was seen as continuously evolving in the process of development and incoming engrams (Plügge, 1978, p. 11).

Goldstein (1939), in turn, was dissatisfied with the studies regarding life that followed the method of working from the lower to the higher, the simple to the complex, under the conviction that the phyla

of living beings demonstrate progressively greater differentiation in their ascending scale. Goldstein attempted to investigate the phenomena of life and made man his point of departure. As the starting point, he studied brain-damaged patients, with the assumption that deficits would reveal phenomena and behaviors that would permit the reconstruction of a point-by-point representation between brain damage location and function (p. 15). However, Goldstein was a physician and therefore examined a physical body, with a view to restoring functions maximizing compensatory ways of living with deficits. The question of facilitating the restoration of health for the purpose of realization of the inner image of the true self seems to have become problematic only recently (Dürckheim, 1982). The debate whether the body could be intellectually known as a schema or representation has been disclaimed by Merleau-Ponty. Rather, the organized skills and capacity of the lived body in a situation can offer some understanding (Benner, 1984b).

Blankenburg (1982) pointed out that the distinction between "Körper" ("body" in English, "corps" in French) and "Leib" as it exists in German addressed two different aspects of being. While Körper is derived from the Latin "corpus", Leib has been associated with "Leben", which means life. Marcel (1978) stated that, "inasmuch as I am Leib (life), I have a Körper (body), but at the same time I only appear to be able to control or have this body at my disposal, precisely because I am this life" (p. 49). The analysis of the lived body by phenomenologists, from Brentano to the present, with Husserl's formula "Zu den Sachen selbst!" (to the things themselves), has become normative for all phenomenological enquiry and applied to the various regions of man's lived experience (Schrag, 1962, p. 203). Both Husserl and Brentano

believed in a representational view of knowledge and perception (Benner, 1984c).

Schrag (1962) claimed that although Sartre, Marcel, and Merleau-Ponty paid attention to the phenomenon of the lived body, "their descriptions are often fragmentary and impoverished on rather decisive issues" and that Heidegger had virtually nothing to say about the body (p. 204). This may be a misconception on Schrag's part but, as Dreyfus (1984b) pointed out, "Heidegger holds the view that the body is not essential" (Chap. 7, p. 45) for directionality. The explication of Heidegger's "Dasein" as "disembodied Existence who moves about in this world of care in an abstracted unawareness of his bodily engagements and orientations" (Schrag, 1962, p. 204) misses the involved, nonreflective stance of the skilled body, which is the basis of a new form of intentionality (Benner, 1984b).

However, the phenomenon in question is the body as concretely lived, which has been perceived as a complex of life movements that are indistinguishable from the experience of selfhood. This necessary connection of locomotion with perception already had been noted by Aristotle and has been accepted as an obvious and necessary condition of a self (Jonas, 1966, p. 99).

Straus (1966) claimed,

> The significance of motility for self-preservation has always been recognized. The significance of motility for consciousness still awaits recognition. Theologians and philosophers have readily attributed to the soul the faculties of perception and thought, imagination and memory, feeling and desire. Even "specious" sensation has been admitted to the kingdom of reason, but movement has been exiled. (p. 40).

Straus perceived human posture and movement as essential for establishing a self which actively searches out, interprets, and gives

to the world. The upright posture is essential for man to become a rational animal, as it opens distances, according to his view. Thus the healthy body constitutes and expresses the meanings of a person's life. It is not only posture but perception that is grounded in the body - to the right, to the left, behind, or above, the reference point is the body.

Bernal (1984) interpreted the necessity of posture and movement to reveal that immobilization may cause changes in a person's self-concept, body image, and self/world relations (p. 80). While the approach of the study is an attempt to provide an accurate and nonreductionistic description of patients' experiences, the data were derived from two interviews of orthopedic patients who had been hospitalized and in traction at least two weeks. The interviews focused on the events that resulted in the patients' hospitalization and the patients' views of the accidents, the effect their situation had on their family, friends, and work, their sense of what they were missing, their sense of the passage of time, and changes in their perception of others and of their own injured limb or body. The conclusions as stated were: first, that the immobilization of a patient should be understood as an existential as well as an orthopedic event; and second, that the patient does not experience a medical diagnosis but a diminished field of action, which pervades all aspects of the self-world, including self-concept and perceptions of time and space (p. 86). Bernal concluded with the hope that the existential problems of immobilized persons will be further investigated and alleviated in the future. Brave words, indeed, with the probable underlying assumption that existence can be ameliorated.

Thus, while we are indebted to Straus for his development of the importance of the fully awake and conscious individual for whom uprightness is the leitmotiv and for whom the world has a distinctive and ever-changing physiognomy, it is to Merleau-Ponty that we owe the discovery of the importance of the habitual body and the world which forms itself around an individual, largely passively and through the intentionality of habit (R. Williams, 1984, p. 94).

Merleau-Ponty has made the notion of a preobjective world central, not only to his phenomenology of perception but to his philosophy as such (Schrag, 1962, p. 201). Van Peursen (1966) stated that Merleau-Ponty elaborated and refined Sartre's ideas of the body/soul realm. The very difference between the two philosophers is that "Merleau-Ponty does not set his account of the body against the background of a wider ontological frame involving a duality of mental and material schemes" (p. 135). Merleau-Ponty set out to show that the manner in which man <u>is</u> his body appears from a large range of phenomena, and all instances where the body is treated as an object turn out to be unsatisfactory (p. 135). The objective body does not coincide with the lived body. Thus, while a scientific theory attempts to present "pure" data, stripped of all ambiguity, anything that is bound up with human sensations and perceptions can never be apprehended in such a pure state; hence the bodily must of necessity be seen in the first person (p. 135). Merleau-Ponty (1981) illustrated how "we are caught up in the world and do not succeed in extricating ourselves from it in order to achieve consciousness of the world" (p. 5). The phantom limb, for instance, is shown as neither a purely psychic nor physiologic phenomenon, nor a combination of both, but has to be approached in terms

of what the body experiences in the first person (pp. 76-77). The body does not have to be looked for, but is that which every act of searching presupposes.

> In other words, . . . the objective body is not the true version of the phenomenological body, that is, the true version of the body that we live by; it is indeed no more than the latter's impoverished image, so that the problem of the relation of soul to body has nothing to do with the objective body, which exists only conceptually, but with the phenomenal body. (Merleau-Ponty, 1981, pp. 431-432)

The objective body is the bleached out, decontextualized idea of what our life is really like and leaves out the lived bodily experience.

As Kruks (1981) pointed out, Merleau-Ponty tried to provide an account of human experience and conduct which escapes the pitfalls into which both positivism and rationalism or idealism stumble. For Merleau-Ponty, the human agent is not a self-sufficient ego or cogito, but rather the body-subject always involved, perceptually and kinetically, with the world. Merleau-Ponty (1983) said that there are no isolated moments or constant sense data, no context-free fragments that can explain what is going on in the world. Reflexes in the classical sense (Pavlovian) responding to isolated stimuli don't exist in the living organism (p. 43). While scientists bought the story and have added to it, Merleau-Ponty said it is inappropriate, as the context of "figure/ground" in which they belong determines their sense. It is these elements that are meaningful, open, and ambiguous; through them we experience the world. The mechanistic view of the body does not work as an explanation of the role of the body and only pushes the problems back (p. 31). Merleau-Ponty denied the one-to-one correspondence of the stimulus-response reflex arc and pointed out that a skill is achieved through multiple senses and skills (Benner, 1984b). Support for his

claims comes from current neurological studies (Hofer, 1982; Weiner, 1972) and from the acceptance of the idea that even congenitally blind persons can "picture" things they have never seen through an intuitive sense of perspective (Greenberg, 1984) or ability to know colors by touch (Sullivan & Gill, 1976).

Dreyfus (1984a) explained that Merleau-Ponty kept the idea that the concept of "in-itself" and "for-itself" (Cartesian view) is inadequate to explain what is going on in the world, and there is something else necessary in order to comprehend the nature of existence. Merleau-Ponty saw as false the idea of the intentional state, which is a representation of what one believes but is independent of what the world is and what can be studied. According to Dreyfus, the whole notion of an object world makes no more sense than the subjective world without the lived body, which Kuhn and Merleau-Ponty expressed as "intentional tissue" which cannot be understood from either the subjective or objective body without the lived body. Therefore, the construction of the lived experience on the basis of the objective body to the exclusion of the lived body is inadequate. Perception is the link we have with the lived experience. Both Dreyfus and Searle are in agreement that, in the final analysis, Merleau-Ponty cannot solve the physical and mental dilemmas and how they fit together or how to arrive at meaningfulness. While Husserl claimed that we give the world its structure, Merleau-Ponty showed how the physical body cannot account for our lived experience.

Benner (1984c) pointed out that, as nurses, we do a lot of interpretation around the body, but that we do not have a theory about the body. According to the representational and reductionistic view,

there has to be something in our head in order to know and explain behavior. However, the sensory-motor ways of knowing work amid ambiguity, and there is no clarity. There is no body that works in a disconnected way and in a decontextualized fashion, in the manner in which science carves up the world.

Jokl (1964) made the distinction between subject and object in the acquisition of skill and stated that both perspectives are necessary since physiology sets out to understand "the theatre of events" and phenomenology searches for insights into the event itself (p. 88). Put another way, physiology is concerned with "the body I have" and phenomenology with "the body I am", as Jokl stated it; he went on to quote Merleau-Ponty, "we do not know how we do what we do" (p. 88). Accordingly, "the muscular system is our sole medium of communication, its differentiation through training represents a major determinant of the individual's capacity to perform as well as to react" (p. 89).

Geschwind (1964), however, claimed that the brain-injured patient is not a unity and found it difficult to accept that this person has a unitary consciousness. He did grant "that in the normal intact person consciousness may be unitary" (p. 100). According to Geschwind, the behavioral sciences have relied too heavily on studying the whole man, while a compartmental approach may be more revealing, especially in studies of children before their associative connections have been fully established.

However, in our common apperception we do not switch back and forth between physiological and psychological modes, and our capacities or activities are experienced as a unity. "The neutral world of objects is a product of the physical sciences" (Van Peursen, 1966, p. 138) and has

detracted from acceptance of a human world of correlation where the world is accessible to us through our bodies. The primary given, therefore, is not dividedness but rather unity, contrary to what Geschwind advocated. Analytic thinking dissects this underlying bond and represents self-subsistent entities and subsequently is obliged to import a synthetic unifying act (p. 139).

The Wisdom of the Body

Dossey (1982) pointed out that the body contains the wisdom derived from countless challenges to its integrity (p. 89). Every time we brush our teeth, we release a multitude of bacteria which are effectively engulfed by white blood cells. Killer cells were not known six years ago, yet probably have been in the service of mankind from the start. Endorphins are a discovery of the last decade but have always served man to endure pain. Thomas (1974) has pointed out that the body is incredibly efficient at the business of health, defending itself against an unending array of intruding forces before we are ever aware of them. The lifespan of an invading organism, for example, is less than four minutes (p. 75).

Wolf (1981) stated,

> Experiments in individual human subjects were automatically innervated indicators such as vasomotor effects of glandular secretions and were observed to change in association with changes in life situation and emotional state or were actually manipulated through stress interviews. (p. 1)

Although there has long been evidence that visceral responses are invoked in anticipation of some activity or in response to feelings, only recently has it been accepted within the scientific community that the automatic nervous system can be voluntarily controlled. Miller

(1969) has demonstrated the direct accessibility of such visceral and glandular response systems to environmental contingency control through operant autonomic learning effects experiments. Wolf (1981) observed that donors of blood transfusions had an automatic and widespread constriction of small arteries, thereby maintaining blood pressure in anticipation of the blood "lost" (p. 3). In other experiments, discussion of intimate personal conflicts induced an elevation in blood pressure and constriction of renal arteries, which persisted for a time in spite of efforts at reassurance (p. 4). Brengelmann (1974) related findings where experienced experimental subjects had an increase in blood flow to muscles to be exercised prior to the experimenter giving the verbal command.

From anecdotal accounts, the ward atmosphere has a marked impact on staff and patients, but this has rarely been documented. When a patient mysteriously improves, we ascribe it to the therapy or the natural course of the disease but have no adequate explanation physiologically as to why the improvement came about. We are even less cognizant of the effect it has on a patient when the care providers have given up hope for recovery. While the health-sustaining role of social support systems has been documented by various sources, the data from clinical settings are negligible.

Marks (1980) observed that the new class of calcium blockers promised great benefits to victims of coronary spasm and related a poignant bit of animal work by Braunwald "that supports the stress relationship; the baboon who went into coronary spasm when someone took away his banana" (p. 40). From the molecular level to the social level, there is evidence of unity or what Merleau-Ponty called "intentional

tissue", which makes us insiders of this world and reciprocal in our relationships, responding meaningfully to situations without cognitively attending to the process. No one understands all of the mechanics of the human organism, "but in general [one] understands well enough until the attempt is made to pass from mechanics to mind, when everything is suddenly blurred, and thin theory takes the place of hard facts" (Eckstein, 1970, p. 441).

To consider the role of the human body from the perspective of the different professions is problematic enough when the body is in prime condition. The picture becomes even further troubled when considering the body's role during illness. Illnesses are believed to occur either as a symbol, in mental illness, or as altered physiology, or a combination of both. How the mind affects molecular changes and alters the position of the atoms inside a cell, how this spreads to other cells or to whole organs "continues to inspire a guessing that keeps our thought on fascinating aspects of life, with mind always coming like light through cracks" (Eckstein, 1970, p. 675).

While some physicians will insist that it is the effect of disease on the mind that is the reality, others will claim that the mind never causes disease. Weiner, Strauss, Fagerhaugh, and Suczek (1979) quoted a nurse who expressed the idea that monitors have become "evidence machines", and the old philosophy that "everything is normal until proven otherwise" now has been reversed to "everything is abnormal until proven normal" (p. 273). Thus technology has introduced an added dimension to the topic of illness. This observation by Weiner and colleagues, that professionals no longer can trust their own perceptions and judgments and have to rely on confirmation from machines, is rather

problematic since the objectification of the patient as well as the health care professional detracts from both of their humanity and "misses the skilled synthesis and graded qualitative distinctions that only the clinician can make" (Benner, 1984b, p. 23).

A View of Personhood and Common Humanity

Sarano (1966) stated that

> If we go beyond a dualism of the soul and the biological body, then, indeed, my body is not this physical body arrested in its pattern and project. It extends beyond itself in all parts; it is project, creation, and life, through the species, through civilization, through culture. (p. 151)

The recognition that nurses can be responsible for a significant effect on their patients by their mere presence "calls for a serious reexamination of studies in which this may have occurred", according to Krieger (1984, p. 296). Yet the effects of "nurses" on their "patients" have been known throughout recorded history, although each generation, or rather each nurse, has to discover this truism for herself. In a study of over 2,000 patients over a seven-year timespan, undertaken to determine the therapeutic effectiveness of several drugs and a placebo on post-operative pain following dental extractions, Lewis and Gordon (1984) found that the nurse was a critical variable on the pain experience and on drug or placebo efficacy.

One of the difficult things to learn as a nurse, doctor, or patient, and even more difficult to teach, is what it feels like to be a patient. Could it be, as Thomas (1983) observed, that in the years past, "when serious illness was a more commonplace experience, shared round by everyone, the doctor [and everyone else, for that matter,] had usually [gone] though at least a few personal episodes on his own and

had a pretty good idea of what it was like for his patient" (p. 220). As long as they believe themselves to be separate individuals, neither patients nor staff seem to perceive themselves as being connected in a common humanity, which is inseparable from the universe and does not stop at the individual's skin. Every human being is a unique person and not an exchangeable unit. However, differentiation does not mean separation.

We seem to make desperate efforts to understand and control life and fix whatever is not pleasing to our fancy. Yet, in spite of the illusions we create, our bodies seem to tell us otherwise, particularly when not performing according to our expectations. There seems to be a nagging Hintergedanken (afterthought) after the most comprehensive accounting of the role of the body.

Sacks (1985) stated, "the tradition of richly human clinical tales reached a high point in the nineteenth century, and then declined with the advent of an impersonal neurological science" (p. xiv). He advocated that the presently practiced mode of "defectology" be replaced by a "narratology", which revives the lost tradition by which patients always told their stories. Once patients have "stories", their common humanity is less likely to be lost, their human world is less likely to be overlooked.

Impact of Notions of the Role of the Body on the Use of Restraints

The belief in a stable world of invariate objects and in the predictability of our life is placed into question when a crisis such as an illness occurs. Sarano (1966) pointed out that certain sicknesses lend themselves better to the idea of sickness-as-sign while others can

be perceived as sickness-as-encounter, with Sartre supporting the former position and Kierkegaard the latter (pp. 164-165). Whether sickness can be a sign for a patient or a symptom for a physician, in the hospital it is the nurse who creates the environment where the scenario comes into action. How the sick person will accept his illness, indulge himself in it or fight against it, will depend to a considerable degree on the attitudes and behaviors of those in contact with him.

Benner (1984b) pointed out that the "bodily ways of knowing and bodily skills are, in the lived form, intentional. Merleau-Ponty uses the term intentional tissue. . . . The situation evokes bodily memories. The body is oriented to the situation in a meaningful way" (p. 27).

From anecdotal reports, the experience of being physically restrained is felt as very unpleasant and conjures up visions of imprisonment, of the pogrom, and of an attack on the self or prevention of the defense of a loved one. The loss of control over bodily movements prevents the habitual and skilled body activities. Since all our perceptions are related to the body we dwell in (Benner, 1984b), this situating power is disrupted and the restrained person is cut off from his/her basic ways of relating to the world. From the perspective of the cultural body, restraining may be particularly negatively perceived, as independence and mobility are highly prized and fostered, even early in life in this culture (Stainton, 1985). While the responses of restrained animals have been studied, those of ill people who are involuntarily restricted have not. Merleau-Ponty (1981) pointed out that

> Illness, like childhood and primitive mentality, is a complete form of existence and the procedures which it employs to replace normal functions which have been destroyed are equally pathological phenomena. It is impossible to deduce the normal from the pathological, deficiency from the substitute functions, by a mere change of the sign. (p. 107)

From the evidence presented, it is reasonable to deduce that the body is responding to the restriction of mobility. "To be a body is to be tied to a certain world, . . . [and] our body is not primarily in space: it is of it" (Merleau-Ponty, 1981, p. 148). The ways in which we interpret and experience illness in which bodily events become the events of the day are tied to the social milieu and reciprocal ties where others are a part of the pattern of the human and cultural world of our perception.

Conclusion

The reduction of the person to a body-as-object may be seen as one of the recurrent temptations of nursing (Benner, 1984b). Of the two most prevalent images of man in nursing, one is the dualistic conception, which has its roots in Christianity and the philosophy of Descartes, where mind and body are considered separate entities. This conception has led to the materialistic view in which only matter is thought to be real, or the spiritual conception, in which only spirit is thought to be real (Frey, 1981). Biomedicine and the natural sciences rely mainly on this materialistic conception of man (Benner, 1984b, p. 9). The other conception of man has its origins not only in Greek philosophy but also in the Darwinian theory of evolution (Benner, 1984b, p. 10). In this view, man is the product of an evolutionary process, with the higher mental phenomena as the only special characteristics of human beings. According to this view, health is the normal condition of

man, and man "speaks" through his diseases about his internal milieu and expresses perceptions which he cannot otherwise properly articulate.

Neither view is comprehensive enough to allow for the nursing profession to care for patients in a manner necessary to perceive each person as a unique being in need of resources to restore or regain the lost vitality or to reclaim his place in his world. To serve the life and health of man has been and is the most important value guiding health care professionals. How this value is interpreted, how life and health are defined, are much dependent upon the prevalent view of man, which ultimately rests with the accepted role of the body.

What ultimately is left out by the Cartesian duality of mind and matter and by the "psychological" or technological self-understanding are human concerns and meaningful action. As Dreyfus and Dreyfus (1986) explain it, ever since Descartes, only the material aspects of life have been legitimized and incorporated into the sciences, leaving out the ambiguous background of custom and experience, which is the core of human experience and skill. In the last analysis, Dreyfus (1979) points out that "all intelligibility and all intelligent behavior must be traced back to our sense of what we are, which is . . . something we can never explicitly know" (p. 56). It is at the heart of this self-defining capacity that the application of physical restraints exerts its subtle role in creating a dehumanizing situation. To restrain a person is to cut off that person's basic ways of relating to the world through the skilled body, the situating power of the body, the habitual and cultural body.

CHAPTER III

METHODOLOGY

This chapter describes the study methods. A brief sketch of the study setting and medical staff is presented. The nursing and support staffs are described and the patient sample is delineated. Methods of data collection, analysis, and interpretation are described. The limitations, issues of validity, and the reliability of the study are addressed.

Research Approach

The design of this study is ethnographic. An interpretive approach is used to investigate nursing practices related to restraining hospitalized patients. The interpretive or hermeneutical strategies follow the phenomenological tradition described by Heidegger (1927/1962). Heidegger provided the philosophical background of the study methods. He saw man's being-in-the-world revealed in everyday lived experiences (Palmer, 1969).

Heidegger's phenomenology is distinct from that of his teacher, Husserl, in the following way. Whereas Husserl was searching for "das Ding selbst", attempting to understand man as the meaning-giving subject

with some kind of a blue-print that had to be discovered, Heidegger saw meaning located "in the social practices and literary texts which man produces" (Dreyfus & Rabinow, 1982).

Hermeneutical phenomenology posits that human beings both constitute and are constituted by their interpretations, which are always based on background meanings within the cultural context. The background for interpretation rests upon skills, practices, assumptions, and cultural mores that cannot be made completely explicit and cannot be completely rationalized (Dreyfus, 1985). The work of Benner (1984), Dreyfus (1985), Geertz (1979), Palmer (1969), Rabinow and Sullivan (1979), and Taylor (1979) explicates and provides examples of this methodology.

The interpretive approach is directed at understanding human behavior rather than explaining it through an unending inventory of attributes linked by causal mechanisms or laws. The shared background of cultural meanings that are taken for granted and are the backdrop against which participants interpret their own activities are not readily available to the outsider or observer. While practices can be observed by others, understanding requires a method which renders the taken-for-granted activities problematic in such a way that another perspective can be gained. The observation and description are interpreted in turn and the meaning uncovered through hermeneutics. Language brings the practices into the public domain and makes them accessible, as it has the capability of bringing it to explicit awareness (Taylor, 1980).

> One might say that language enables us to put things in public space. That something emerges into what I want to call public space means that it is no longer just a matter for me, or for you, or for both of us severally, but is now something for us, that is for us together. (Taylor, 1985, p. 259)

Taylor offered a picture of man as a self-interpreting being. This self-interpretation he saw as essential to human existence and articulated through language (p. 76). This study describes and interprets a nursing practice of using physical restraints in context. The goal is to delineate the meanings nurses ascribe to their activities, the meanings inherent in the practices, and to capture the patient's perspective. From the interpretation of the gathered data, the explanation of the practice of how nurses account for the use of restraints will be given.

Ricour (1979) described four ways in which the text derived from interviewers and observations differs from spoken language. First, the datum is fixed in time. Second, there is a dissociation between the verbal meaning of the interview from the mental intention, permitting an examination in a larger context of statements from a number of nurses, patients, and family members. Third, by extracting salient features from specific situations, the descriptions can be seen as part of a larger tapestry. Fourth, the transcription permits the description of relevant context.

The study describes restraining practices to increase the scope of understanding by mandating that the interpretation makes sense to a larger audience. Since there are no isolated facts, the strategy of hermeneutics is to systematically move from the whole to the parts, understanding each in terms of the other.

The Research Setting

The study took place in a general public teaching hospital which has a proud tradition and has been claimed to be one of the country's finest. The hospital is a seven-year-old modern H-shaped structure with three older hospital buildings surrounding it. The licensed 582 beds are distributed over nineteen nursing units.

The data collection for this study was conducted on a thirty-four-bed medical ward. The department of medicine admits patients to three wards and to some special care areas.

Physical Setting

The construction of the ward under study has the patient rooms along the west and east sides of two long hallways, with two two-bed, two single-bed, and the day room facing south. Both hallways have entrances to the main corridor of the hospital. However, the one closest to the elevators was the one mainly used. The two hallways were connected at three points: at the nursing station, indirectly through the nurses' and doctor's conference rooms, which are joined, and through the day room (or TV room, solarium). The conference rooms are divided by a harmonica door and are accessible through doors from opposite hallways. There are a total of fourteen two-bed rooms, six single-bed rooms, one bath, three showers, a medication room, dirty service room, an office each for the head nurse and clinical specialist, a supply closet, kitchenette, broom closet, and staff bathroom, in addition to the already mentioned conference rooms. Each of the patients rooms has its own bathroom with a toilet and attached bedpan flusher and sink.

The structural dimensions of the setting have considerable impact upon the flow of work, the accessibility to equipment and supplies, and the ease or difficulty experienced in monitoring patient activities. The design along two long hallways contributes a great deal to the distance the staff has to travel and the time spent in transit. However, how the participants within the environment dwell in the setting is of more import for the purpose of the study. The next section will describe the medical staff.

The Medical Staff

The hospital is affiliated with a major medical school and university and serves as training ground for a variety of health care professions. The population that surrounds the hospital is mostly in the lower-income group. This population generally uses the emergency room of the hospital as its primary mode of obtaining medical care. The medical staff therefore sees patients under conditions that are considerably less orderly than those of patients in settings where there is a referring private physician who has done some diagnostic work-up and provides a medical and often psychosocial history of the patient. The house staff - that is, the intern or medical student who is responsible for doing the work-up of a newly admitted patient - is therefore frequently faced with a patient who is either not in a condition to provide the necessary history or who is a poor historian. The intern and medical student thus organize the routine but necessary clinical care to be done. The intern can write medication orders and admit patients to the hospital; for the medical student it is necessary that all orders are countersigned.

The next rung on the medical hierarchy after the intern and medical student is occupied by a resident, who is responsible for the day-to-day management of the patients. The resident may have several interns and students on the team. Two chief residents essentially function as attending physicians in the absence of the latter; they arrange for teaching sessions, rounds, seminars, and anticipate and treat problems before they occur. At the top of the hierarchy are the attending physicians, who are responsible for the patients on their service. However, there were variations in the number of individuals assigned to each service and in the ranks that were filled. The variations in manpower are unrelated to patient load and are determined by the scheduling demands of the students, interns, and residents. Thus a resident on any one of the medical services was responsible for the work of five or six interns and medical students and from anywhere from ten to twenty-five patients.

The medical students and interns were transient with monthly changes of service; consequently they had little opportunity for collegial relationships with nursing personnel. While the photos and names of interns were displayed in the conference room for easy identification and legitimacy, those of the medical students were not, so the nursing staff generally had to look at their nametags to find out their names and status.

Four attending physicians had admitting privileges on the ward where the study was conducted. However, other services frequently admitted to this ward as well, when necessitated by the bed scarcity of the hospital or when isolation rooms on other services could not be obtained. The ward thus presented a tremendous bustle of activity,

especially during the time of morning rounds, which start at 8:00 a.m., when an additional twenty to thirty people would crowd the hallways in groups of five or six and the noise level and obstruction to the flow of work reached a high.

The interns and medical students described their rotation on the medical service as particularly hectic, the medical problems complex, and their own survival threatened by a perpetual lack of sleep or rest. The main responsibility resting on their shoulders, from their perspective, was the challenge to gain expertise in diagnostic skills and become confident clinicians. The house staff are held accountable for management of their patients. In case of any error attributed to nursing, the severity of the infraction was dependent upon the appraisal by the house staff, who then reported this to the appropriate authority. Thus the administration of a liter of intravenous fluid over a half hour in an 84-year-old woman was neither reported nor recorded by an intern, while another insisted a missed laboratory test be reported as an "incident" to the head nurse by writing a physician's order on the chart. Generally, the medical staff assumed the nurses would know what was needed to be done to carry out the treatment. However, since the experienced nurse perceives herself as showing the house staff how things are done in this setting, while the house staff feels a sense of responsibility and conferred authority, some tension is inevitable if their views and priorities diverge. Generally, the execution of physician's orders proceeds with a maximum of efficiency and is dispatched with a minimum of friction.

Physicians were not asked individually to participate in this study, but the study was introduced to the resident and attending staff

as a group, and their comments are incorporated in the text on an ad hoc basis.

The Sample

The convenience sample was comprised both of nursing and support staff who worked on the ward and patients on whom physical restraints were used. The size of the nursing staff sample was forty (75%) of a potential fifty-three, which constituted the permanent staff, and the size of the patient sample was forty-two, or 51 percent of the total number of patients who were in physical restraints during the time of observation. The characteristics of the nursing and patient samples will be depicted in greater detail.

Sample characteristics of the nursing support staff. The sample was comprised of the registered nurses practicing on this ward; the licensed practical nurses (LVN) of the sample were not determined prior to data collection but rather evolved as data collection progressed and as a consent to be a participant was obtained. A description of their performance of activities reflects common meanings inherent to nursing practice within the setting. This study focused particularly on the meaning embedded in the use of physical restraints.

A total of thirty-one registered nurses, three LVNs, two aides, two orderlies, and two unit clerks participated in the study. The age range of study participants was from 22 to 60 years, with a mean of 34.53 years. There were thirty-nine females and one male. There were seven Caucasians and thirty-three from other ethnic groups, with a predominance of Asians among the professional nursing staff and Blacks and Hispanics in the support staff group.

Selected educational, experiential, and employment characteristics of the study participants are depicted in Table 1. The number of years of employment ranged from one month to forty years, with a mean of 4.74 years. The length of employment on the ward under study ranged from one month to sixteen years, with a mean of 1.37 years. It is noteworthy that the registered nurses' mean age was 32.81 years compared to 42.67 years for the LVNs and a mean of 50 years for the orderlies and aides. By the same token, the length of total employment for the registered nurses, with a mean of 6.38 years, compares with 12.33 years for the LVNs and a mean of 29 years for the aides and orderlies. More significant is the length of employment on this ward. The registered nurses showed a mean employment of 1.87 years and the aides and orderlies a mean of 6.5 years of employment at the present location. While a comparison of length of employment at the same institution may have been revealing, this information was not elicited. From references to the institution's history, which was frequently alluded to by employees with a tradition, it is safe to say that some unit ward clerks, aides, and orderlies and four of the nurses had been employed at the same institution for over ten years. The comparison of this group between the new and old hospital structure was particularly illuminating in terms of the special arrangements and creation of a habitat for both patients and employees.

Fifteen of the participants did not comment on the question regarding their future career plans. Two of the participants stated that they felt their present position and employment was so challenging that they would consider this question only in the event that their employment should become boring. Four of the support staff were looking

TABLE 1

Number of Nursing Staff by
Employment Status and Program Type

Employment	Program Type* 1	2	3	4	5	Total
Unit Clerks	2					2
Aides/Orderlies	3		1			4
Learned Vocational Nurses		3				3
Registered Nurses		3	12	15	1	31
Total	5	6	13	15	1	40
Years of Employment						
0 - .5	1			2		3
.6 - 1			1			1
2 - 4	1		5	5		11
5 - 10		2	5	6		13
11 - 20	1	3	2	2	1	9
More than 20	2	1				3
Total	5	6	13	15	1	40
Years of Employment on the Ward						
0 - .5	1	2	3	4		10
.6 - 1		1	4	4	1	10
2 - 4	1	2	4	7		14
5 - 10	2	1	2			5
11 - 20	1					1
More than 20						0
Total	5	6	13	15	1	40

* 1 = On the job training; 2 = Diploma; 3 = Associate Degree; 4 = Bachelors in Nursing; 5 = Masters of Nursing

forward to their retirement, and one aide was aiming for a two-year program to become a registered nurse. Five of the nurses wanted to enroll in an intensive care course, and one was interested in embarking on a teaching career in nursing; five nurses stated that they wished to attain a bachelor degree, two a masters, and two were interested in finding a better-paying job.

One of the striking features about the staff in general was their small physical statures compared to the clientele they served. The inclusion of the heights and weights on the staff profiles revealed the following statistics. The range in height was from 4'1" to 5'8½", with a mean of 5'2"; the weight ranged from 98 to 170 pounds, with a mean of 121 pounds.

More revealing are the staff profile data presented in Table 2, grouped according to the three shifts, categories of staff, years of employment on the ward, and their height and weight. On all three shifts, the registered nurse was the youngest in age, had the shortest length of employment on the ward, and the majority were smaller in height and weight than the support staff. When comparing the three shifts, the registered nurses on the day shift emerged as the longest employed on the ward, and the taller and heavier nurses were in this group. That is not to suggest that selection to the different shifts is made on the basis of those physical characteristics, but rather that it reflects that the day shift is the preferred work schedule for most and is attained through longevity at the working place rather than through selection. It is worthwhile to note in this context that, of the nine Caucasian nurses, seven were working the day shift, and two of those in

TABLE 2

Nursing Staff by Employment Status, Shift Worked, Age, Length of Employment on Ward, and Height and Weight

Shift and Status	$\bar{X}$ Age in Years	$\bar{X}$ Years of Employment	$\bar{X}$ Height	$\bar{X}$ Weight in Lbs.
Day Shift				
RN	33.90	3.6	5'3"	117
LVN	37	5	5'1"	130
Aides/Orderly	45	5	5'2½"	135
Evening Shift				
RN	29.13	1.4	5'2"	128
Orderly	60	16	4'11"	128
Night Shift				
RN	32	0.9	5'1"	108
Orderly	52	6	5'2"	140

an administrative capacity. While the most frequent length of employment was 1.5 years on the day shift, it was one year on evening and one month on the night shift. The support staff on all three shifts had the longest employment on the ward. The implications of the data will be made more explicit in the next chapter, where the conditions of the work will be described.

The patient population. The total number of patient days for patients with physical restraints was 496, or 14.12 percent of the total patient population on this ward. During the first period of observation

the percentage of patients in restraints was 15.01 percent, and for the second period 12.53 percent. This slight change was reflective of the changed patient population between the two periods of sampling; the striking difference between the two sampling periods was related to the difference in patient population. Whereas, during the first period, alcohol-related reasons for admission were as high as 40 percent of all patients on the ward, there were only 17 percent of patients in this group during the second sampling period. The nursing staff accounted for this difference as due to the warmer weather in March and April and the closure of one medical ward.

Sample characteristics of the patient population. The sample of forty-two patients who participated in this study was made up of thirty-two male (76%) and ten female (24%) patients. Some demographic data for these patients are presented in Table 3.

TABLE 3

Selected Patient Characteristics

Characteristics	Males (n = 32) Range	$\bar{X}$	Female (n = 10) Range	$\bar{X}$
Patient Age in Years	35-93	59	28-91	64
Length of Hospitalization in Days	2-111	20	5-56	20
Length of Time in Restraints in Days	.17-87	13	3-32	11
	n	%	n	%
Ethnicity: Caucasian	23	72	8	80
Other	9	28	2	20

The average age of male patients was 59 years and for the female patients, 64 years. Of the male patients, twenty-three were Caucasian (72%) and nine of other ethnic origin (28%), compared to eight female Caucasians (80%) and two of other ethnicity (20%). The average length of twenty days of hospitalization did not differ between genders, but deviated considerably from the average length of stay for medical patients in the hospital (about six days) and for the total ward population (five to six days).

The length of time in restraints for male patients ranged from four hours to eighty-seven days, with an average of thirteen days. Female patients had a range of three to thirty-two days in restraints, with an average of eleven days. No comparative figures from other wards in the hospital were available.

The above data are grouped according to the chronological sequence of data collection and depicted in Table 4. The patients in the second sampling group were older, had a shorter hospitalization, and shorter period of time during which they were in restraints. However, the difference between the two samples becomes more evident by comparing diagnosis of the patients (Appendix A). Whereas twenty-five patients (78%) of the first sample were admitted for alcoholism-related reasons, two (25%) patients in the second sample fell within that diagnostic category. The change in patient population held true for the total ward and could not be explained on the basis of preferential admitting or seasonal variation.

TABLE 4

Selected Patient Characteristics
According to the Time of Data Collection

Characteristics	November to February		March to April	
	Male (n=28)	Female (n=6)	Male (n=4)	Female (n=4)
Patient Age in Years				
Range	35-90	28-86	57-93	31-91
Mean	56	60	74	65
Ethnicity				
Caucasian	20	4	3	4
Other	8	2	1	0
Length of Hospitalization in Days				
Range	2-111	5-56	6-22	10-29
Mean	21	23	13	15
Length of Time in Restraints in Days				
Range	.17-87	3-30	4-17	7-10
Mean	12	13	9	9

The types of restraint used between the two samples are illustrated in Table 5 and Table 6. The types of restraint presented in Table 5 apply to the total patient population in restraint on this ward (N = 82), while Table 6 gives the breakdown for the sample of the study (n = 42). While quantitative data regarding the type of restraint, length of time of employment, and use of immobilizing equipment are given for the entire patient population in restraints on the ward, further analysis is confined to the study sample. Of the eighty-two patients observed, 82 percent were continuously confined in restraints,

TABLE 5

Total Number of Patients in Restraints According to Number of Immobilized Parts of Body, Days of Use, and Percentage (n = 82)

	Number of Immobilized Parts of Body				
	1	2	3	4	5
Total Patient Days in Restraint	223	134	81	27	29
Percent of Patients in Restraints	44.96	34.00	16.33	5.44	5.85
First Sampling Period					
Number of Patients	136	134	73	26	24
Percent	34.59	34.00	18.58	6.62	6.11
Second Sampling Period					
Number of Patients	87	0	8	1	5
Percent	86.14	0	7.00	.99	4.95

with the most frequent means being the use of the Posey jacket, classified as "one-point restraint". As depicted in Table 5, 45 percent of patients fell into that category; 86 percent of the patients in the second sampling period were confined in this manner. Overall during the second sampling period, fewer restrictions were applied, as is evident from the data presented in Table 5. None of the patients in the second sample were found to be in two-point restraints, as compared to 34 percent in the first sample. Only 7 percent as compared to 19 percent were in three-point, 1 percent versus 7 percent in four-point, and 5 percent versus 6 percent in five- point restraints when the second sampling group is compared to the first one.

TABLE 6

Type of Restraint on Study Sample According to Number of Immobilized Parts of Body and Length of Time of Confinement (n = 42)

	Number of Immobilized Parts of Body				
	1	2	3	4	5
Total Patients in Restraint	36	8	27	7	12
Total Patient Days in Restraint	315	80	82	22	31
Mean Days in Restraint	8.75	10.00	3.04	3.14	2.58
First Sampling Period					
Number of Patients	28	8	23	7	10
Number of Patient Days	239	80	72	22	28
Mean Days	8.54	10.00	3.13	3.14	2.80
Second Sampling Period					
Number of Patients	8	0	4	0	2
Number of Patient Days	68	0	10	0	3
Mean Days	8.50	0	0.40	0	1.50

A further breakdown of the data from the participants reflecting the length of confinement within the different types of restraint of the study sample is shown in Table 6. While the average length of time of patients in one-point restraints did not differ between the first and second sampling group, fewer restrictive means of restraint were used; that is, none of the patients were found to be in two-point or four-point restraints in the second sample. Of the four and two patients in three- and five-point restraints, their confinement was much shorter than for the patients in this group in the first sample.

Data Collection Methods

Data collection procedures included participant observation, brief unstructured interviews with patients, and structured and unstructured interviews with the nursing staff. The data collection of the study was preceded by three field studies to determine the feasibility for this work and one in the present site, which extended over four months. Hence the familiarity with the staff and site extended over fourteen months, while the data collection was completed within a six-month time span. A total of 708 hours were spent during this duty, seventy-eight hours during evening and twenty-eight hours during night shifts. While the researcher was introduced to the nurses on the three different shifts as a group, individual introduction to the study was necessary to gain consent for observing the nursing staff in their work. The observation and verbatim exchanges which were captured in the field notes, together with data from the patients' records, served as the basis for interpretation. The clinical situations were collected on a daily basis, with two interruptions of four and thirty-six days respectively, for a total of 120 days. Participant observation was deemed essential for the methodology because the nursing staff and the patients may not describe the many aspects of their knowledge and activities. The nursing staff take much of their work, knowledge, and skill for granted. They perceive the domain through the transparency of their cultural (clinical) background without being aware of it or making it explicit. While for many of the observed patients verbal expression of their perspective was not possible, the description of their activities and behavior served as the basis of analysis.

A brief demographic questionnaire was used to describe the characteristics of the nursing staff participants and their preparation and experience (see Appendix B). A patient profile was used to gather information regarding the patients (see Appendix C). Following the first sampling period of three consecutive months, confirmation of some of the observations was sought by using a semi-structured interview guide (see Appendix D). In addition, accounts given by nurses and doctors in their written and verbal reports provided another opportunity to gain insight into the staff's perception and understanding of the patients.

Human Subject Approval

The study protocol was reviewed by the University of California, San Francisco Committee on Human Research and approved (No. 944208-01). The study was approved by the Research Committee of the hospital where the study took place, after a request to the researcher to comply with some additional guidelines (see Appendix E). Consent forms for the nursing staff included a brief description of the study and a copy of the Bill of Rights (see Appendices F and G) and were signed prior to observation periods. Participation was voluntary, and participants were instructed to determine the situations when they did not wish the researcher to observe them in their work or make statements they did not wish to be recorded. Anonymity of the participants was provided by assigning a two-digit number to each.

An information sheet describing the study was given to the patients after they had given verbal consent to be participants in the study (see

Appendix H). Verbal consent was witnessed and signed by a staff member after reading a verbal consent statement (see Appendix I) out loud, as per institutional request. The participant was assigned a three-digit number, and confidentiality was enhanced by separating the name from the information. None of the patients who were asked refused to be participants in this study, but several were not deemed by the staff to be capable of giving informed consent.

Reasons for not being able to obtain consent were attributable to unfamiliarity with the patients, or staff members' reluctance to witness the verbal consent, or inability of the patient to give consent. Of the forty patients from whom consent could not be obtained, ten patients had a psychiatric illness or had taken an overdose of drugs and were transferred to the psychiatric unit within a day or two. Eight patients were in delirium tremens, six were found to be too demented by the staff to be considered capable of informed consent, five patients died before consent could be witnessed, another five patients presented language barriers that could not be resolved, and three patients were too old to comprehend what the study entailed. One patient was felt by the staff to be incapable of giving consent "because she says yes to everything".

One of the obstacles to getting consent from patients was attributable to the necessity for a staff member to witness the consent. Thus, when a patient said "I don't care" instead of "Yes", the nurse felt reluctant to countersign the consent. At other times, patients oriented in one or two spheres were found to be incapable to participate in the study. The evening and night shifts were particularly cumbersome in obtaining consents, mainly due to distrust of the researcher and unfamiliarity with the process.

Interpretation and Analysis

The field notes and information from the patient profiles and interviews provided the text for analysis and interpretation. The observational and narrative accounts were collected with as much circumspection as possible and described within the context in which they took place. The preservation of the context is necessary to limit possible meanings of the situation. As Benner and Wrubel (1982) pointed out, the narrative form "assists in securing sufficient detail, thinking, and chronology for the listeners to understand the incident and for the interpreters of the transcript to grasp the essentials of clinical knowledge exemplified in the encounter" (p. 14). The text was derived by direct observation from an interpretive value-laden point of view. The recorded materials reflect feelings, ideas, and conditions that seemed to occur often enough to merit consideration.

Data analysis systematically scrutinized the text for repeated themes and commonalities that allowed for some generalization and grouping of clinical situations and patient scenarios. The observation and interview methods facilitated the discovery of new concepts and permitted the exploration of conditions under which they occurred. The text was analyzed by moving from the whole to parts to the whole, and interpretation continued until a satisfactory understanding was achieved. Analysis proceeded by comparing the whole of the patients' clinical sojourn with individual episodes during confinement. Patient confinements were compared with each other and the commonalities or differences accounted for. The circular process of interpretation undertaken, where interpretation of the text leads to further

interpretation, is referred to as the "hermeneutical circle" by Taylor (1979).

Consensual Validation

The investigator verbalized to participants the interpretation of clinical incidents to determine the veracity of the observed events whenever possible. Committee members were presented with the text and groupings of clinical scenarios for concurrence or nonconcurrence with the interpreted meanings and to enhance further interpretation. The grouped clinical episodes were presented for independent analysis to two clinical experts and a colleague for consensual validation and avoidance of an inaccurate interpretation. In this study, the clinical episodes were interpreted by looking for recurring themes or connections. The threat to validity due to observer bias is managed by this consensual validation and the multiple stages of interpretation.

Observer Effect

A major validity concern in participant observational studies is the effect of the observer on the gathered data. However, the notion of a neutral observer of raw data has not been claimed for this study. While qualitative researchers have found a decreased influence of observer effect over time, the presence of the investigator in the clinical setting at times did alter the typical pattern. This happened to be particularly so in the instances where the nurses would anticipate the researcher's activities at the bedside of a patient and relax her usual vigilance in monitoring and caring for her patient. Observer effects such as these can alter the accuracy of the actual observation

on how the patient received care and occurred frequently until it came to the awareness of the researcher. Some of the nursing staff were not able to ignore the presence of the investigator and hence continued to give a performance. It underlines the fact that the ethnographer does not stand outside the situation and admits to the influence of the researcher on the study. The level of objectivity aimed for in this study was based on the notion that it can be attained through the shared meanings with others similarly situated. This can be called a situated objectivity rather than objectification through decontextualization.

Summary

In this chapter the research approach has been described with an overview of the philosophical background for the methodology. Selected characteristics of the research setting and the participants were presented, as were procedures and processes of data collection. The interpretation and analysis of the data were depicted and issues of validation were addressed.

CHAPTER IV

FINDINGS

The purpose of this chapter is to describe the work in the setting in which the study was carried out. The views held by various professional groups and individuals are stated and the work required to take care of the patients is described. The depersonalization of both staff and patients is depicted to facilitate the reader's understanding of the restraining practices within this setting.

Organization of the Work

The nurses worked in two teams. These are divided geographically by two hallways along which the patients' rooms were located, numbered by even or odd numbers for the rooms and designated as the "even" and "uneven" sides. Nurses preferred to work on one team only for any given shift, as the distance between rooms and hence legwork is reduced and the provision of care was less cumbersome, for reasons addressed at a later point.

There were no obvious differences between the two teams since the members were freely exchangeable as work requirements arose, and the teamleaders - designated by the head nurse - negotiated with each other. The length of the work periods is eight hours, and the three shifts

differ in composition as already described. The provision of care to the patient during the three shifts was also found to differ, while each group of staff felt they were the ones who were the busiest, hardest working, and providers of the best nursing care on the ward. From patients' statements, they felt most cared for during the evening and night shifts.

No obvious difficulties between the three shifts were observed, although individual idiosyncrasies do exist. While the nurses on evening shift may get to know the patient better as an individual, this information is not usually passed on to the next shift nor documented in the various places designed for this purpose. Thus the staff frequently did not know their patients beyond the immediate medical diagnosis and treatment plan and current condition.

Views Expressed about the Staff and Patients

The views held of the staff by various people outside the ward yielded a discrepant picture. One of the supervisors felt that the nurses on that ward were the hardest working and most cheerful in the whole institution, caring for very acutely ill patients who would be in intensive care units in other hospitals. Since this individual was working on a part-time basis in many other hospitals within the geographic location, she seemed to have a sound basis for comparison. From the investigator's perspective, too, the patient population as a whole was the sickest and most debilitated encountered anywhere over the past thirty years of clinical experience in diverse countries.

The director of nursing service was very complimentary about the leadership instituted by the installation of the head nurse with her own commencement of tenure at the site. She felt the staff turnover rate, which had declined from 50 percent to 35 percent, was a good indicator of effective ward management. The investigator noted that the nursing staff wore designer uniforms, and the director attributed this habit to the good example of the head nurse. At the same time she disclaimed the existence of a model dress code for the nurses in the hospital generally. The values the assistant nursing administrator held concerning the staff could not be verified as he did not provide the opportunity to be interviewed. However, from comments from the staff it seemed evident that he supported the head nurse's decisions, which was also corroborated by the observation of his behavior whenever he came to meet with the head nurse.

View Expressed by the Medical Director

It appeared important to consider the perspective of the chief of medicine, since he directs the medical department and therefore the ward under investigation. He meets with the head nurses, administrative assistant, and clinical nurse specialist weekly to discuss any newly arisen or potential problems of diverse origins; predominantly, however, the meetings are intended to facilitate the smooth functioning of the department. He expressed his admiration for the head nurse and said saw her as "a fine, dynamic young lady". He also indicated how much the running of the ward had improved since she took office. However, since his main focus during the interview was on the topic of this study, his views will be addressed in a subsequent part of this chapter.

Views of Medical Students, Interns, and Residents

From informal comments, the medical staff within this category expressed their insights about the work performed by the nursing staff, saying that they themselves could not do it. Those interns and residents who had experience with other county hospitals in the country stated that this institution was the best in terms of the delivery of nursing care, support services, and supplies. Since their rotations on the medical service are particularly hectic, they rely greatly on the nursing staff to monitor their patients' conditions and to notify them of changes. While the majority of nurses would address this group of physicians by their title and surname, the nurses themselves were always called by their first names. The distinction most likely underlines the expectations held by the nursing staff, that is, that they carry out the treatment plan for the patient as prescribed by the physician. The observed discrepancies between the medical staff and the nurses, few as they were, centered around the issue about physicians' orders that were either questioned by the nurse or could not be accommodated within the expected period of time. while the nurses are protective toward the medical staff, the reciprocity is not prominent at the patient's bedside. Generally it was conceded that the purpose of the medical staff's sojourn on the ward was to provide them with an opportunity to learn and gain experience. The daily (or less frequent) visits by the attending medical staff on the ward could not be observed to have any direct impact on the nursing care of the patients investigated.

Views Held by the Relief Nursing Staff

The majority of staff who come to work on the ward when there were inadequate numbers of permanent staff members are registered nurses. Of the thirty-two different nurses the investigator encountered, twenty were observed only once, six were observed twice, three were there three times, one ten times, and one sixteen times. While this group of relief nurses generally are in the minority, there were days when this order was reversed. The comfort with which this group provided nursing care to the patients depended upon whether or not they liked the regular staff, the kinds of patients and treatment regimens, and whether or not they "floated" on a regular basis. Some of these nurses expressed the sentiment that they would rather have foregone the pleasure of earning a living than come to this ward. While they make their objections known to the nursing office, they were not always successful in being accommodated in their requests. Generally, they attributed their reluctance to work on the ward to the lack of helpfulness they perceived in the permanent staff (who were there predominantly during the day shift).

Others felt this ward was not any different from other wards in the hospital and expected a heavy work load. Only one of the relief nurses who returned most frequently worked consistently with a permanent staff member as a team. This was probably more a reflection of the fact that she belonged to the same cultural group as the majority of the nurses. The one day when this nurse had to work independently, as there was only one other nurse on duty, her husband phoned her usual cohort to complain to her about deserting his wife, and he held the cohort responsible for making his wife work so hard. The sense of the larger community being

involved in the work of the ward usually escapes notice. An account of what the work consists of from the nurse's perspective is depicted next.

Work on the Ward

Work on the Day Shift: Report from the Night Nurse

At 7:00 o'clock on the morning, all nursing staff and the unit clerk assemble in the conference room for the report from the respective team leaders on night shift. The number of staff always exceeds the available space and number of chairs, which results in spilling over into the adjacent doctor's conference room. This arrangement, however, makes understanding of what is being said by the night nurse difficult, as the noise from the hallways interferes and the traffic in and out of the conference room is continuous. Since, for the majority of the staff, English is a second language, their accents and shift of emphasis makes what is being said not easily comprehensible. Thus some of the staff, while physically present during the report, may not necessarily have heard what was being said.

The staff members who listen to both team reports are usually the charge nurse and unit clerk, the head nurse on week days (if no other administrative functions deter her), and some nurses who at the mid-point of the report don't yet know on which team they will be working. While the team leader listens to the report on the patient of her team, whoever received the information first leaves the conference room to check the patients and start assigning duties; therefore she often doesn't know what is going on on the other side of the ward.

The night nurse reported the room and bed number, name, age, medical diagnosis, any changes in the medical treatment plan, tests to be done for which the patient needs to be prepared, or tests which were not able to be completed on the previous day. The blood pressure, pulse and respiration, and input and output are stated, as are any changes in the patient's condition and any steps that had been taken in response to those changes. One night nurse consistently provided a summary of the physical assessment on each patient, which the day staff did not perceive as being particularly helpful. In the day nurses' estimation, the report of physical findings denoted more a self-enhancement on this nurse's part than concern for the patient and sound clinical judgment.

The night report lasted about half and hour and was followed by the assignment of work by the team leaders, who had negotiated with each other about who was going to work on their team for the day. While the staff generally are assigned to the same team on which they worked the previous day, staff returning from a day off may be shared or have to work on the side least familiar to them. Frequently there is only one orderly on duty, who is shared between the two teams. Helping with the care of as many as eight to ten of the most dependent patients and as requested by other staff in need of assistance keeps her in constant demand. The workload for the nurses is usually five or six patients and three or four for the team leader.

Inventory of the Work or Time Management

The organization of the tasks to be accomplished is very much dependent upon the individual nurse and where she places the emphasis of her professional mandate. Generally, aided by the information from the

preceding shift and the brief instruction from the team leader, she makes her own assessment by checking out her patients first; frequently neither the team leader nor the nurse for the day are familiar with the patient. The priority in what needs to be done first depends upon the patient's physical condition; that is, the most critical, unstable patient is taken care of first, while the most dependent for assistance may wait until last. However, the linearity of the chronological sequence depicted here is very misleading as there are usually several tasks to be accomplished by the nurse all at the same time. Usually the administration of drugs ranks uppermost in importance, as a missed dose is tightly monitored by the pharmacy department and reported to the head nurse on a daily basis. Medication errors serve as basis for being "written up", which has dire consequences from the staff's perspective.

While the nurse attempts to give morning care to her patients, and usually does get around to making the bed sooner or later, the form of hygiene maintained leaves room for wide interpretation and is not perceived as a priority. The investigative procedures ordered for the patients and therapies to be carried out off the ward hold precedence over the activities of daily living that usually contribute to a patient's comfort. Thus the patient may or may not have had a bed bath or shower by the time breakfast arrives at 9 o'clock, but he is usually placed in a Gerichair if dependent upon assistance for his ambulation.

The molded plastic trays used for the delivery of patients' meals are brought by a dietary assistant, who drops the tray onto the designated bedside table, as space permits, or bed if it is vacated. To make the food accessible to the patient does not seem part of the job description of this support staff. The lid covering the tray provides

an obstacle to the sick, since lifting it off the tray goes beyond the strength of the debilitated. In any case, access to the food is by no means attained by removing the lid. The plastic cutlery is firmly encased in a plastic bag that defies access, cereals and liquids are sealed within their respective containers, and unless the patient has two hands he can use as well as adequate strength, he is dependent upon assistance from the nursing staff. Although a drinking straw was included on the tray during the earlier part of this study, for the last month this item was missing and increased the leg work of the staff three times a day.

Depending on the number of patient who needed to be fed their meals, and whether or not assistance from support staff was available, plus the nurses' own physical needs, she may or may not go for a coffee break to the cafeteria. However, between 10 and 11 a.m., most of the nurse's time is spent in the administration of medications and taking vital signs. Only very rarely is there a patient on this ward who does not receive pharmaceutical agents at least once a day. Whatever time remains between the administration of drugs and lunch time is filled with the continuation of giving morning care, carrying out prescribed treatments, and checking up on new doctor's orders, which are usually written after the physicians have completed their rounds and conferences about 11 a.m.

During the period between 11:30 a.m. and 1:30 p.m., when the staff takes turns to go for lunch, whoever is left behind on the ward is particularly busy, since neither patients nor medical staff tolerate much delay in their requests and largely perceive anybody in uniform as an exchangeable unit at their service. However, the observation is

probably somewhat distorted due to the brevity of the stay on the ward of both the medical staff and the patients, as well as the multitude of nursing personnel whose names the first two groups have a difficult time remembering.

At about 2 o'clock in the afternoon, patients who have been sitting confined in chairs since before breakfast are returned to their beds. Once again vital signs are measured, input and output are totalled, and a note is made of how much intravenous infusion will be left in the bag at the end of the shift. Whatever treatments and medications have been prescribed on a four-hour basis are administered, and the records on the progress notes and treatment sheets are charted and signed off. What is referred to by the staff as "charting" is a time-consuming activity, as most progress notes are more than one page in length. It is the rule rather than the exception that the nurses leave work late, because they do not find the time to complete their charting. Curiously enough, the nurses who were consistently late and had frequently been observed staying as much as two hours longer were apologetic for not having been organized or fast enough to finish on time. Rather than perceiving their nursing care as engaged caring that elicits from them a constant involvement with their patients and an attuned monitoring of their needs, these nurses blame themselves for being too "skills oriented".

Such as linear depiction of how nurses' time is structured on a day shift is an oversimplification of what really occurs. The ease with which the staff deal with shortages in supplies and obstacles to their attainment, as well as the hindrances in giving care due to environmental structures or policy mandates will be addressed in the following section. While the day shift is the most hectic in terms of

activities, the number of people milling around on the ward, and the noise level and interactions, the treatment plan does not vary significantly for the patient on the other two shifts.

Since the staffing of the ward is done by patient census through the nursing office, the number of nursing staff on the day shift may be one person more than on the evening shift, and the evening shift, in turn, may have one more than on the night shift. The day staff perceive themselves as the hardest and fastest working group, while the other two groups think the same of their own shifts. Generally, there is little reflection on any circadian rhythm in the treatments and activities that go on. It is not uncommon that a patient selects to be discharged after 10 o'clock at night, or signs a consent form for an operation to be performed at 2 o'clock in the morning, or is woken up for that purpose because the intern didn't get around to it before. Investigative procedures, or treatments that are omitted, take precedence over a patient's sleep and are not perceived as counterproductive to a therapeutic regimen.

Mastering the Workload under Conditions of Scarcity

Few items to carry out the treatment plan are predictably available. Searching for supplies becomes a norm rather than an exception, and the staff is accustomed to either improvise when it is possible or frequently do without a needed item. Paper tissues seem to be an item which was frequently lacking on the ward, but more cumbersome were shortages in linen, blankets, dressing gowns, or slippers. While some supplies were requested by nurses directly, some were supplied on a scheduled basis, while others were obtainable only through a request by

the head nurse. The frequent shortages in supplies enticed the staff to cache items among cupboards along the hallways and rooms. Futile searches for items can be quite time consuming, but a nurse who was observed looking through a dozen cupboards for a pillow did not seem to be irritated, and accepted this condition as normal.

Frequently, securing the desired piece of equipment required a phone call to the respective department to ascertain the availability of the item, filling out a requisition, and finally going to obtain it. While a pneumatic tube system is available through which requisitions can be sent, no delivery service is available to bring the items to the ward. Thus much time is spent in transit to secure whatever is missing on the ward, or to go to the cashier to retrieve patients' valuables or money to pay for the rental of a television set. Under this rubric of fetching also falls the frequent trips to the emergency department to borrow a stretcher, as none are routinely on the premise. While the cashier and emergency department are geographically the most distant, trips to the central supply room or pharmacy can take just as long, since the service is at times less than efficient from the time-pressured nurse's perspective. However, while the staff has become accustomed to improvise or do without, things such as the inadequate availability of wheelchairs for transportation are a daily nuisance. While two of these vehicles were on the ward at the beginning of the study, within a month there was only one. A "shanghaiing process" was noted by one of the nurses, but she was overpowered by the verbosity and insistence of the perpetrator that the item belonged to the latter's department.

Although there were four Gerichairs available, they were not used for transportation of patients off the ward as "they were expensive and would get lost". This unwritten policy resulted in a great expenditure of effort and energy, as patients were transferred from Gerichairs to wheelchairs to be taken to physiotherapy or occupational or speech therapy, or all three at separate times and for some patients twice a day; then they were either returned to the Gerichair or to the bed on their return. Actually, it is the nursing staff who gets the workout, as they are resigned to the view that all other employees responsible for the transport of patients have been "hired with broken backs" that prevent their giving any assistance in the transfer.

Another constant drain on the available time comes from the call lights which, when activated, summon the attention by a most annoying pulsating buzzing sound, and the lights go on outside the patient's room and on both hallways at the nurses' station. Thus each time a patient calls, nurses on both teams are alerted, who then look up and down their respective hallways to see whether the request is on "their" side and therefore from one of their own patients or not. Since this call system is a constant sensory bombardment, the attention to the summons is filtered out when other demands take priority. Since the call lights can only be shut off from inside the patients' rooms and no intercom system is available to inquire about the patient's request and determine the urgency with which to attend to it or negotiate a postponement, an unsurmountable chasm was created between the patient's and nurse's perspective in their diligence in answering the requests for assistance.

The urgency to go to the bathroom is one of the most prevalent themes that creates much distress for the patient and additional work

for the staff. The delay in the needed assistance, being encumbered by Travenol infusion pumps which have non-wheeling wheels, extension cords that are too short to permit access to the bathroom without unplugging the machine from a wall outlet inaccessible to a sick patient, and confinement to a bed with siderails sets a scenario which subsequently can lead to the application of physical restraints. Four of the rooms had doors blocking access to the bathroom, which provided an additional obstacle, particularly if the patient was in a Gerichair. However, all the patient bathrooms were too small to accommodate any additional equipment.

One practice that had become so integrated into the nurses' work that it escaped notice was the obstacle course that needed to be performed to start an intravenous infusion. To obtain the solution, the medication room was entered - which required a key. The dressing and infusion set was obtained from the supply room by punching four digits on a lock and twisting the lock and door handle simultaneously - which required two free hands. Next, the alcohol swab and needle or angiocath were obtained by opening a drawer (by key) on the medication cart. If it was a new intravenous infusion for a patient, a requisition was made out and an infusion pump, which was referred to as the "bubble machine", was collected from the central supply room. The designation of the name came from the fact that a minuscule bubble, invisible to the eye, within the infusion line would trigger the alarm on this machine and made the technological advance over counting drops questionable.

However, the greatest scarcity seemed time in which to accomplish the work. Because of the high turnover rate of the patient population, neither the arrival nor discharge of a patient was a noteworthy event

except for the nurse who had to leave her assignment to attend to the admission or admissions, if several arrive at the same time. However, the team leader or charge nurse usually helped to process the orders and help in writing up the care plan, and the patient was "worked up" with great efficiency in the shortest possible time. But there are limits to how fast and efficient a nurse can accomplish her work. When one nurse was trying to give the 10 a.m. medication and received her second admission at the same time, she said to the investigator, "You have no idea what it is like. You have to do it before you know what it is really like." Although being placed "on hold" for ten and fifteen minutes to arrange discharge mediations and making return appointments to the outpatient clinic may be extreme cases, the nurses involved assured me that it was by no means unusual.

The team leaders on each shift for each side of the ward made out a report to the nursing office that stated that total number of acuity points for the ward, any anticipated problem that may arise, critically ill patients, patients in restraints, or any patient who may have grounds to question their treatment under less trying circumstances. To compile the acuity levels, each patient's requirements for assistance in the activities of daily living and treatment regiment is checked and predetermined values are assigned. However, while this administrative tool is designed to monitor what is required, depending on the interpretive skill of the nurse. the form is updated according to what should be done. While some nurses see this activity as mere "paper work", for others it is their "most hated job" as it takes as much as thirty minutes for each team leader. Since neither the derived dependency levels nor acuity values are used for the purpose of staffing

from the nursing office or on the ward, it is held by the nurses on the grass-roots level to be a waste of their time. The other aspect involved in this activity is the demand by the administrative staff that on each shift two charts be audited to determine the accuracy of the assessment and to maintain vigilance. The head nurse assigns two "auditors", but the latter have the freedom to select the charts which they survey. New orientees to the setting are instructed in this fine art of keeping the administrative staff satisfied and dissolving the conflict of feeling as if they are "ratting" on their colleagues when they find discrepancies, by a new interpretive style which their "instructors" explain as the capability "to read between the lines".

However, from the administrative perspective, the assessment tool is taken very seriously and charts are requested to be audited on both evening and night shift by the supervisors on each ward. The noted discrepancies between the nurse's assessment and updating and that of the administrative staff is compiled and made public in the local newsletter to reward those "least busy" who can devote their time to paper work. While any introduction to help the staff on the ward is hailed as the most advanced, professionally necessary, and sound, the staff who have been around longer see it as a ploy to squeeze more work out of them, making it more difficult to deliver the necessary care as they see it. Acuities are only one item among several that are assigned to be audited; it is the most vigorously monitored and time consuming and seen as a measure of the nurses' performance of their duties.

The compilation of what contributes to the scarcity of resources such as equipment, supplies and, most important, time is by no means exhausted with this report and will be dwelled upon in subsequent

accounts. The work of the physicians will be addressed next, to round out the context which makes it possible and permissible to apply restraints to the sick and dependent.

The Work of the Medical Staff

At the top of the hierarchy are attending physicians, who take the overall responsibility of all patients under their service for the duration of time they are the "staff man" for the month. In a strict legal sense, the attending physician is responsible for what happens to patients under his care and is the final authority in any disagreements with the house staff. However, such discrepancies could not be monitored consistently as they would either come to the fore only when an intern or medical student was directly asked for a rationale for a treatment decision or investigative procedure or discussion ensued between the attending physician and the resident or intern at the bedside during rounds. Whatever discrepancies existed between the attending physician and medical staff were resolved during their conferences that followed their rounds on the wards as part of the teaching program. The smooth running of the service is further assured by the chief resident, who would assume much of the teaching during rounds and who would monitor the residents, interns, and medical students and function as attending physician in the latter's absence.

Below this level of authority are the residents, who assume a supervisory role over the interns and medical students on the service. Thus, while the residents lack responsibility for the entire service, they have great responsibility for anywhere from one to two dozen patients. Keeping the ordered medications appropriate, the

investigative procedures pertinent, treatments ordered as necessary, and maintaining smooth working relations with nurses all seem to be part of the responsibility of the residents.

At the bottom of this hierarchy are the interns and the medical students, who do the "real" or, as they refer to it, "scut" work of the routine but necessary clinical care. Since their work day is structured with "work rounds" on the wards starting at 8.00 a.m., attending the resident's report at 9:30 a.m., 10:30 attendance at rounds or Grand Rounds followed by research conferences, morbidity and mortality conference, medical service conferences on different days, and then daily X-ray rounds starting at 1:30 p.m., there remains little time for such mundane activities as having an unhurried meal. In this discipline, too, great emphasis is placed on the thoroughness of daily charting, admission histories and discharge notes, the rapidity and sophistication of investigative workup, and prescription of the most aggressive treatment plan to battle the disease within the shortest time span. While the explanation that is given for this approach is founded on legal and/or economic grounds and supported by a scientific rationale, this view does not permit an alternative perspective that may accomplish the same ultimate outcomes by less drastic technological means. Thus the treatment plan is prescribed by clinically inexperienced doctors who, because of their own time pressures and learning needs, see the highly technological approach to patient care as the only acceptable and sound method of caring for patients.

From comments by this group, it appears that the rotation through the medical service is seen as the busiest and most energy depleting. Some of the interns expressed frustration with "repeaters" who, as far

as the interns' learning needs are concerned, do not provide "good material" for their experience, and "social admissions" were felt to be the least welcome. Thus the focus was to work up the patient as quickly as possible on admission to arrive at a diagnosis and rule out any plausible alternatives and actively pursue a treatment plan which would combat the underlying ailment.

Through the daily ongoing review of the performance by peers and supervisors in the hierarchy, standards of acceptable performance are set in advance on the basis of objective criteria and maintained as the most systematic and expedient way to do the work. While the nursing staff recognize that they have to show any new member on the medical team the ropes or how to do things on the service and how to comply with the policies of the institution, how to obtain the equipment for their investigative procedures, order medications, and so forth, the emphasis lies on the maintenance of the ward order rather than the translation into an effective exchange of what the clinical pictures looks like from the patients' and nurses' perspective.

While the accuracy of a patient's daily weight measurement may become an issue, the fact that it caused much pain and discomfort for the patient and took up to four staff members to obtain it never arose. Thus the physician in charge of solving the clinical problem and of ordering the treatment plan is frequently unaware of what his orders mean for a patient; his premise is that he orders it "for the good of the patient".

The most startling observation regarding the nurse/physician interactions is their infrequency. That is, the nurses are busy carrying out the treatment plan and the doctors are busy doing their

assessments and investigational work without the two professionals comparing notes or observations on a consistent daily basis. Thus the decision to discharge a patient or change of order came frequently as a complete surprise to the nurse and could not be ascribed to a miraculous recovery and restoration to health. Conversely, the physicians were frequently unaware of the difficulties in implementing their treatments and of how much the patient's suffering was increased - and concomitantly the nurse's work was complicated - when approaches less cumbersome could have accomplished the same goals. Schatzman (1986) termed this as a "Hollywood production".

The only formal occasion when physicians and nurses sit together occurs once a week when the respective intern or resident presents his "problems of disposal" to the social worker. The interaction takes from ten to twenty minutes for the physician, and the focus is entirely on the discharge of patients and the appropriate placement. On the occasions when heated debate ensued, with the physician insisting that the ward was no longer the appropriate abode since nothing more could be done and the patient occupied valuable space, which prevented access for the acutely ill, the social worker expressed her view by saying, "They make it sound as if it was my fault that there are not enough facilities available in the city where those people can be taken care of."

In this regard, it is of interest to note that the medical and nursing staff would talk about patients who had become pros in the institution due to their frequent return as "repeaters", while the social worker referred to them as "regulars". While neither of their professional seriousness is in doubt, by which each group sees their work as ennobling and of dignity, worthy of exerting one's energies for

the betterment of the sick and needy, the role assigned in an institution limit the professional to displaying certain pieces of knowledge, and the totality necessary for action is created only by the whole collective, the institution as such.

The Devaluing of Staff and Patients

The perplexing problem of how both the staff and the patient become diminished in their common humanity is briefly touched upon; depersonalization is more specifically identified. The architectural design of the setting has been presented, pointing to the increase in leg work, the time requirements to do the work, and the difficulties of monitoring patients. As a concomitant of scarcities in time and resources, many delaying and diversionary tactics were used to circumvent complying with a patient's request which could not be gratified immediately and with reasonable ease. The fidelity to establishing a trust relationship with a patient was jeopardized, but also the nurse became diminished as her explanations to a patient often sounded to him like lame excuses or, worse, that she didn't like him. The established work routines neither sensibly organized the work for the nurses nor provided the likelihood of helpful care to the patient. In order to discover the particular needs of a patient, the nurse must actually know him and how he perceives himself and others. However, often the patients stated that there was nobody they could talk to or that nobody would listen. The control of unacceptable behaviors through the use of silence and looks of disapproval to force compliance were observed to be techniques employed by a few nurses. Ignoring patients'

requests at one time or another was also prevalent. The patients in the study were generally seen as untrustworthy or unsafe or both.

There was ample evidence that patients were considered to be separate and wholly other by the nurses and physicians. Patients were not considered to be of the same class of community or to have the same values. This separation and "nonmembership" made them more vulnerable to the loss of civil liberty. Devaluation and dehumanization carry with them the threat of an erosion of the patient's autonomy. For example, one nurse stated, "The patients here have a different value system. They don't care about hygiene and cleanliness the way we do."

Patients are categorized as "they", while the staff unite as "we". This separation, common in conflicts, puts a strain on the sense of common entitlement. This was illustrated by the orderly's statement, "The alcoholics in withdrawal aren't in a life-threatening situation. They shouldn't have a sitter. They can have their own hangover and the city shouldn't have to pay for it."

Not conversing with the patient, or talking with a colleague while attending a patient, or speaking in the staff's native language occurred frequently and corroborates the interpretation of patients being considered nonentities or wholly "other". Devaluation and stigmatization, while not the only cause for the use of restraint, make the consideration one might give to a member of the same community dispensable or nonessential.

Conditions such as alcoholism and drug abuse were closely followed by the diagnosis of AIDS for a devalued or stigmatized patienthood. The presence of lice or scabies was a more transient state and, together with a disheveled, poorly groomed appearance, were remedial situations

that could be restored or reversed. More permanent dependent states that made patients unable to take care of their own toileting, or those where recent memory only reached two-digit figures in terms of seconds, were also seen as troublesome by the staff. Behaviors such as the persistent urge to smoke by the patient, which at times led to the disruption of treatments, was also not valued nor seen as necessary by the staff. However, the issue of infringement of a patient's civil liberties will be addressed in due course. Suffice it to say at this point that the conditions which rendered the patient as wholly "other" than the staff were usually a composite of several states, conditions, and behaviors that made the patient more vulnerable to this devalued existence.

Frequently patients encountered censure for their inadequacies such as expressing their experience in lay terms. Their life style and economic impoverishment was highlighted by the discrepancy between the staff and patients. Subtle messages that were verbally or nonverbally communicated increased the social distance between the staff and patients. For example the well-groomed nurses stand out in sharp contrast to the poorly-groomed, disheveled patients. Social distance and dissimilarity heighten the separation into two camps. Little community is experienced between patients and staff. During times when the ward was particularly short-staffed, nurses often wondered whether administration was even aware of the important and difficult work they were doing "for them".

Although one nurse stated that discrimination and prejudice existed between the staff and patients, she felt it was never at the expense of the necessary treatment. Another nurse said that she has become more

interested in the medical aspects and treatment of diseases: "I no longer seen them (the patients) as people."

With increasing specialization in nursing, the negative pressures - that is, to feel degraded by working on a general medical ward - have permeated the feelings of many of the staff. The following statements from the nursing staff should come as little surprise:

> "They treat us like animals here - they think we <u>are</u> animals, in fact."
>
> "Thank God they have an excellent health insurance in this place. Even the administrators know that this place is the last they would like to be when they are sick."
>
> "Thank God I will never have to be a patient here."

Generally the staff felt they were the "step-child" of nursing administration, and one of the more senior nurses told a new orientee that she was throwing her life away by working on this ward. One of the most persistent frustrations concerned the frugal reimbursement for overtime, that is, getting paid for 30 minutes when staying two hours. The threat of being "written up" and "getting it from all sides" was troublesome for some, while others saw working around the system as a challenge.

While there was no ideology for restraints, there were expressions of strong sentiments by the nurses regarding alcoholics, drug abusers, and homosexuals. Since generally the patients seemingly had unlimited needs and could not postpone the gratification of their wishes, they clamored for attention from uncertainty or from habit, not taking it for granted that they would be cared for.

Summary

The conditions under which the work takes place have been delineated for both the nursing and medical staff. The most pertinent items contributing to the perception of a real or perceived scarcity of manpower and supplies have been depicted. The importance of the maintenance of the work order has been alluded to, and it has been suggested that the practical and social knowledge of the care providers create the boundaries and define the location of their domain within the social structure. The devaluation whereby both patients and staff become reduced in their common humanity has been shown as a complex issue and emerges as a contributing factor in the use of restraints. The next section will describe what constitutes restraints from the staff's and patient's point of view, the conditions under which patients come to be confined, and what affects continuation of their use and finally terminates their application.

CHAPTER V

DESCRIPTION OF RESTRAINTS

The description of restraints together with an inventory of what does or does not qualify as restraint in the setting is presented. The circumstances under which patients are confined by restraints are depicted, as well as the conditions which perpetuate the state and what brings it to an end. Patients' behaviors and reactions to the application of devices restricting their mobility are revealed.

What are Physical Restraints

A physical restraints is any physical appliance or device that prevents free physical movements the patient would otherwise be capable of performing. This distinguishes restraining practices from verbal restraints, which are used to shape patients' behaviors in congruence with the situational mores and serve to teach patients their role in an acute care institutional setting. The treatment regimen is preserved through the compliance of the patient. Should a discrepancy arise between the patient's understanding of what is necessary and prudent for his betterment and recovery and the understanding of the health care professionals, it is predominantly the latter's perspective that will prevail unless the patient poses a danger to the staff by his

threatening, violent stance and his physical condition is not critical.

While the equipment used in the treatment of patients poses a hindrance to their ability to be freely mobile, the acceptance of the impediment is dependent upon the patient's appraisal of their efficacy, his knowledge and experience of hospitalization, and his familiarity with the setting, and physical condition. All of the above aspects influence the tolerance with which he accepts or rejects the discomforts, irritation, or pain of the devices used in his treatment. The medical staff prescribing the treatment, however, perceive the practice of restraining from the point of medical necessity and what is the customary, acceptable treatment regimen for the identified ailment. From the nursing perspective, the adherence to the doctor's prescription is dependent upon the nurse's own appraisal of risks and benefits, to the patient and to herself within the system.

While different patients are tolerant to various degrees to their own hierarchy of sensitivity, the frequency with which devices would be dislodge, picked at, or pulled out would give some indication to their acceptability, generally speaking. Interestingly enough, the acceptability does not reflect invasiveness of body cavities but rather the irritating factor. While oxygen via nasal prongs may not be an impediment to a patient who is not moving his head, if the flow rate is increased, it may revert to being irritating to the patient and hence removed. If the patient does not voice his discomfort to the physician who ordered it in the first place and who then can either explain its necessity or discontinue its use, the scenario that ensure usually goes along the following lines. The nurse will come into the patient's room and on each occasion replace the nasal prongs on the patient's face,

explaining that the patient needs the extra oxygen for his breathing, comfort, or to make him feel better or to help him get better. While this explanation in itself does not sound like verbal restraint, with the last statement some coercive element is introduced.

A face mask over the patient's nose and mouth may appear more restrictive or confining and is indeed perceived by some patients as less acceptable than the nasal prongs, but for an unshaven face it may be the more comfortable alternative. While one item of equipment may in and of itself be of little import, it may become the last straw that breaks a person's patience. The impact of the individual device used must be seen within the context of what else is going on with the patient. However, from observations, the two most frequently dislodge items are nasogastric tubes in both female and male patients, condom catheters for male patients, followed by Foley catheters, rectal tubes, and intravenous catheters, in that order. One patient accidentally pulled out her peritoneal catheter twice by getting out of her bed while undergoing peritoneal dialysis. Invasiveness, from an outsider's perspective, does not always predict when or if a tube will be pulled out. For example, the tracheostomy tube of one patient never presented any curiosity to be explored manually, although the comprehension of verbal instructions was doubtful.

The range of acceptability of any artificial device is furthermore dependent upon the individual patient's belief and attitude toward the medical technology, as well as familiarity with the equipment and their own physical condition. One patient, observed during a pilot project, expressed it in terms of her total rejection as a "child of nature" to having such foreign material as dentures put into her mouth, while

another patient during this study welcomed any intrusion into his body because intensive medical therapy, for him, was more prestigious and redeemable for secondary gains.

After this general introduction, restraints will be discussed more specifically in the subsequent sections.

Verbal Restraints

The patients in this study are those who were designated by the staff as being in restraints. This group, however, does not exhaust the practices that limit a patient's mobility. At any given time patients are verbally admonished to keep still, not to move, and not to do something which can range anywhere from a gentle reminder or plea for cooperation to severe commands, from whispers to shouts depending on the urgency and potential severity or dire consequence for either patient or staff or both. When a patient has a chest X-ray taken, he is asked to take a deep breath and to hold it; most times he is told when he can breathe again in his usual manner. This procedure holds true for patients who can cooperate and negotiate on their own behalf. For a dyspneic patient, despite his best efforts at cooperation, the situation can become quite stressful as the X-ray technician attempts to obtain the very best exposure to prevent a repetition of the ordeal, and the patient is too exhausted and drained of energy to appreciate the relevance of yet another procedure robbing him of comfort and ease. Thus, while this investigative procedure is "nothing" as far as the staff are concerned, it is "quite something" for a debilitated, sick patient.

The practice of venipuncture once, twice, or even more often, daily for the acutely sick is another example. The transient method of verbally and often physically limiting movements of the upper extremities for the purpose of withdrawing a blood sample or establishing an intravenous infusion is so routine for the staff that any patient objecting to submitting has to be "straightened out". This can take the form of "talking the patient into it", where the nurse convinces the patient of the importance of knowing the laboratory values to monitor his therapy, or where an intern attempts to take a blood sample without preparing an aphasic patient for what he is about to do. The patient's withdrawal of her arm with each of his several attempts and his inability to accomplish the task make him give up and he explains on the progress notes that the patient was "combative". Because of the patient's inability of comprehensible speech production under duress, the intern assumed she was also unable to comprehend an explanation regarding the necessity for the procedure or incapable of making a decision, nor should she be given a choice regarding it. Her body language of withdrawing her arm and moaning noises were passed over as irrelevant to the situation.

Patients who refused to have their blood sample drawn by the phlebotomist between 6 and 7 o'clock in the morning were, from both the nursing staff's and the house staff's point of view, seen as "more work". The one patient who clearly stated his reason for his refusal - that "it hurts" - was cause for laughter of agreement, but clearly he was not seen as capable of deciding what was appropriate for him.

Thus the verbal restraints together with the physical immobilization of a limb ranged from "just make a fist, open and close

it a few times; now hold it; a small needle prick is coming now; that's fine, you can open your wrist again" to "if you don't keep still, I'll break your arm" or "I'll kill you". It would be misleading to compile a verbal restraint inventory which would lend itself to a rank order categorization as the context in which the verbalization took place needs to be included. While in some instances the admonitions were for the purpose of exerting power and control over the patient, in most of the observed instances the intent was to keep the patient safe and prevent the staff from having additional work. The expressions most commonly heard were to the effect of delaying immediate attention - "just a minute; wait; don't do that" or to prevent injury - "you are going to hurt yourself; you're going to fall; you're going to kill yourself; you're going to bleed to death".

Another category of limits to patient mobility can be seen as concomitants of the technological gadgetry deemed necessary to carry out the treatment plan. This aspect is scrutinized and delineated in the next section.

Equipment and Modes of Treatment Which Confine Patients

Of the eighty-two patients observed, only one had no intravenous infusion (Table 7). While an intravenous infusion in itself does not hamper the free movements of a patient, when the solution is administered through a Travenol infusion pump, activities become limited for a patient wishing to get out of bed. The extension lines between his arm and the machine are limited in length and, unless the patient alights from the side of the bed on which the machine is located, the likelihood of a disconnection is great. This was the case when the

TABLE 7

Equipment Limiting Mobility
(n = 82)

	Patients		Days		
Equipment	n	%	Total n	Range	$\bar{X}$
Intravenous Infusion	81	99	783	1-63	9.67
Foley Catheter or Condom	41	50	487	2-68	11.88
Oxygen Therapy	31*	38	272	1-70	8.77
Nasogastric Tube	21	26	171	2-50	8.14
Rectal Tube	15	18	118	1-21	7.87
Peritoneal Catheter	2	2	8	2-6	4.00

* Oxygen therapy included 22 patients with nasal prongs, 3 with face mask, and 6 with mist hood.

patient ventured further. One of the most pressing reasons for a rapid exit from the bed which led to the disconnection of the intravenous line or pulling out of the angiocath was the need to use the bathroom. Even in the instance where the patient is cognizant of the necessity of maintaining the intravenous line, the difficulty of pushing a gadget which does not wheel easily or has to be unplugged from a wall outlet presents an overpowering obstacle.

The patient's attempt to keep a clean bed by attempting to make it to the bathroom on time, which inadvertently led to the disruption of his infusion, was never overheard as being praiseworthy by the staff. From the patient's point of view, however, it seemed obvious that they did not purposely subject themselves to the added discomfort of having

another intravenous line established. From the nurse's vantage point, the reestablishment of an intravenous infusion could be quite troublesome and time consuming. In one instance the night nurse reported, "We had to sick him twenty times before we could get another IV in." In another instance, when the event was timed, it took twenty-five minutes with a cooperative patient. Frequently, another person was needed to hold the patient's arm still while inserting the angiocath. Hence it was quite a common practice to protect the integrity of the intravenous infusion by whatever means.

The use of an arm splint was one way of keeping the infusion running and of providing extra protection to prevent disruption. The size of the appliance was dependent upon the placement of the needle and the availability of splints. Neither the immobility through an arm splint nor the suspension of the arm with a skyhook were considered immobilizations by the staff and were mostly accepted as a matter of course by the patients.

Oxygen therapy via either nasal prongs or a facemask was variably experience as either facilitating the relief of symptoms or, when the patient was unaware of any relief or didn't comprehend the necessity for it, as quite an irritation or annoyance. Oxygen therapy was administered to 31 (38%) of the 82 patients observed; the route of oxygen delivery was via nasal prongs (n = 22), via face mask (n = 3), and by mist hood (n = 6), as depicted in parentheses in Table 7 under "oxygen therapy". However, more irritating to the patient was the presence of a nasogastric tube (n = 21 or 26%), regardless of its purpose. While patients admitted with an upper gastrointestinal hemorrhage usually fell in the category of "patient pros" and were

familiar to the staff - that is, their behavior could be predicted. Frequently, hospitalized patients in this institution acquired a high level of sophistication about how the system works and practically requested their own treatment plan. The ten patients in the study with a nasogastric tube made repeated successful and unsuccessful attempts in removing the tube. The frequency of the attempt at removal was dependent on the person's tolerance, how tightly the tube was taped to the nostril, the degree to which the tape hindered unimpeded vision and, in male patients, whether or not it stimulated the moustache hairs. While the size of the nasogastric tube may be an additional factor, the flexibility of the tube was more important and hinged on the synthetic material from which it was made. Although a nasogastric tube was no hindrance to movements, when attached to suctioning equipment or connected to a Travenol pump for tube feeding, mobility restrictions were inevitable.

The second most frequently used tube after angiocaths were urinary catheters and condoms (n = 41 or 50%), and these were the most frequently pulled out, after nasogastric tubes. Condom catheters were usually kept in place by the patient until the time came when the patient needed to void and he would instinctively feel for his penis and remove the condom. The nurse, on finding the bed wet, would reapply the condom after changing the bed, whereupon it would stay intact until the next time the patient needed to void. I will return to this later, as the pulling out of catheters and condoms led to further limitations in mobility. None of the patients with Foley catheters or condoms were observed to have been ambulated other than being placed in a Gerichair or wheelchair.

Rectal tubes, which were attached to drainage bags, were used for patients incontinent of liquid diarrhea (n = 15 or 18%). While the equipment works quite well in keeping the patient clean and dry in an obtunded bedfast patient and no doubt contributes to the prevention of decubitus ulcers, in the patients who sat up for lengthy periods the catheter became more of a hindrance to the patient's comfort and they frequently pulled out the tube. Of the 42 patients in the study, 13 (31%) had iatrogenic diarrhea, which followed the administration of lactulose prescribed for alcoholic patients at risk of changes in mental function and liver failure. The priority in treatment was aimed at keeping the patient lucid, displacing the patient's experience and comfort as of lesser importance.

Peritoneal catheters became a limiting factor when the patient was being dialysized (n = 2 or 2%) and were attached via the tubing to the monitoring machine. Only one patient, who did not comprehend this limited range of movement, was put into restraints because she attempted to go to the bathroom.

The investigational procedures that required the patient to remain in bed for a prescribed period of time were frequent, but usually performed during the immediate period following admission, when the patients were usually placed on bedrest by the physician. The frequency with which a patient was confined and tied with a stretcher belt was so common that it became noticeable only under unusual circumstances. One evening a patient waited two hours for transportation to have a CAT scan, when the procedure was cancelled for the fourth time. While this happened to be a depressed, emaciated, monosyllabic gentleman, it can be assumed that it was nevertheless an imposition and probably

unforgettable to lie still for this length of time tied to a stretcher. However, the staff expected such instances of discomfort to be tolerated, assuming that the patient would accept the importance and necessity for the investigative procedure in assisting the intern to arrive at a diagnosis.

Patients who were tied down to the chair with a sheet or two were never counted by the staff as being in restraints. Neither was the use of Gerichairs, which kept the patient confined by the lapboard that snapped onto the armrests and provided a tabletop (50% of the sample).

Siderails were a permanent feature of the electric beds used and were always raised unless the patient was completely ambulatory. However, even in the latter case, whenever the patient was in bed the nurses would automatically raise the siderails. While the siderails only block easy access to the top half of the bed, for a patient hindered by other equipment, the extra distance necessary to get out of bed was an impediment for the sick. From the nurses' perspective, however, anything that prevented the bedbound patient from independently alighting from the bed was a positive feature.

Taping an arm with adhesive tape to the siderail was also not counted as a restraint as it was a temporary measure, as was taping the patient's head to the Gerichair to prevent the head from drooping onto the patient's chest for the purpose of taking a chest X-ray.

Patients who required the wearing of a cervical collar or needed the use of an abduction pillow or armsling or leg splint were not considered by the staff as being in restraints. One patient had a face mask put over his mouth while immobilized by restraints because he had

spat at a visitor in the elevator as he returned from an investigative procedure. Taking all the foregoing into consideration, one may ask what constitutes physical restraint? This will be delineated in the subsequent section.

A Description of What Constitutes Physical Restraint

The institution had opted to purchase a limited selection of devices manufactured by the Posey company for the purpose of providing for the safe administration of treatments. It was felt that the equipment offered by this company was the sturdiest and best designed because of the durability of the materials used in the manufacture and was considered the least expensive because of the virtual indestructibility. The devices available were adjustable limb holders, control mitts, safety vests, and sleeved and unsleeved jackets. The limb holders were lined with synthetic fur with a Velcro closure with two 30-inch cotton straps, designed to fit an extremity without tightening or loosening.

Hand control mitts with rigid palms, looking much like a table tennis paddle, came with straps that were tied to either the bed or wheelchair for further immobilization. Safety vests were infrequently used when the desired size of Posey jacket was not available. The vest is designed to prevent the patient from sliding or falling out of bed or wheelchair, with slots in front where the straps are pulled through before being tied to either vehicle.

The sleeved or unsleeved jacket comes in white or plaid cotton in four difference sizes, with color-coded trim. For a snugger fit, side

ties on either side adjust up to six inches on each side and shoulder loops are attached, providing options for additional support. A zipper on the back of the jacket is offset to one side to provide comfort and is overlapped with a flap closed with Velcro tabs. A long cotton strap is sewn onto the waistline and provides long ties on either side of the jacket for attachment to bed or wheelchair. Posey adapter straps are used on the beds to provide extra safety in the use of the devices. The adapter straps were used on the hard pan beds, fitting around the metal surface with two D-rings underneath the bed to which the ties of the restraints were fastened. A mandatory inservice program for the nursing staff assured the exemplary application of the restraints (Appendix J), the charting on the checklist every hour, and adherence to the policy of the institution regarding their use (Appendix K).

Leather restraints were used at times when the patient arrived in them from the emergency room, until they could be replaced with the "soft" restraints permitted for use in the wards. Although locked leather restraints were available in the hospital, those were not used on the ward and were reserved for a psychiatric ward, with a separate policy for their use. However, quite a proportion of the "repeaters" among the patient population were familiar with either the leather or locked restraints and hence found the "soft" type to be an improvement.

Designation of the Severity of Restraints by the Number of Confined Body Parts

The classification of severity of confinement through the application of devices that limited or inhibited mobility was stated along a five-point scale. One-point restraint was either tying down one

extremity, usually at the wrist (Figure 1), or the immobilization of the upper torso by using a Posey jacket or vest (Figure 2); 78 percent of the observed patients were in this category (Table 8). Two-point restraints were the confinement of either the two upper or lower extremities, or one of each, or one limb and use of a Posey jacket; this included 18 percent of the patients. Three-point restraints restricted either three extremities or two limbs and the application of a Posey jacket (38% of the patients) (Figure 3), while four-point restraints were the restriction of movement of all four limbs, or three limbs and the torso (12% of the patients). Five-point restraints involved the four extremities and the application of a Posey jacket, observed to be used on 23 percent of the patients (Figure 4).

TABLE 8

Classification of Restraints by Confined Body Parts
(n = 82)

Number of Points of Restraint	Patients		Days		
	n	%	Total n	Range	$\bar{X}$
One Point	64	78	434	1-44	6.78
Two Points	15	18	168	1-50	11.20
Three Points	31	38	106	1-10	3.42
Four Points	10	12	29	.17-12	2.90
Five Points	19	23	46	1-7	2.42

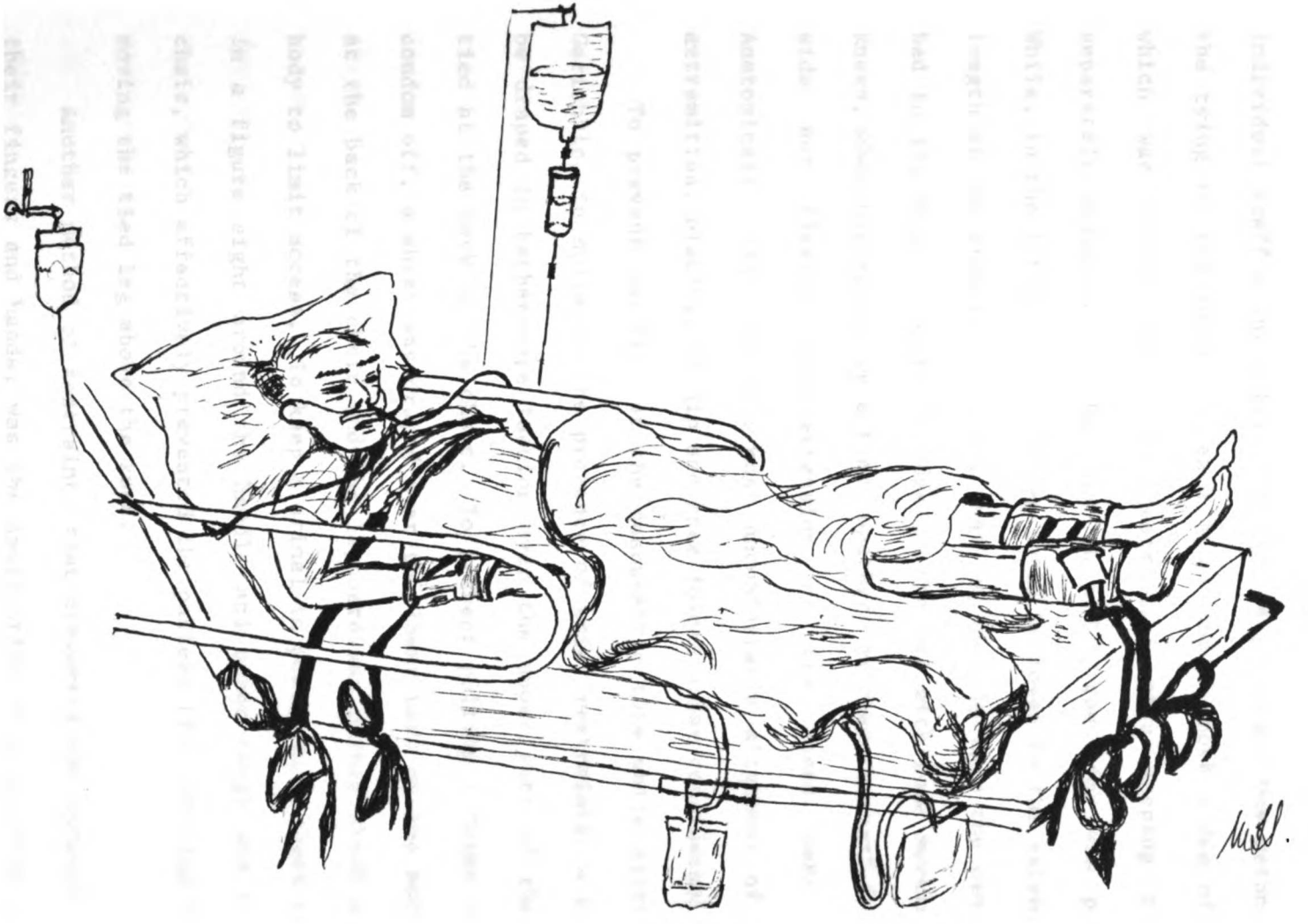
One-Point Restraints

Figure 1

Figure 2

Three-Point Restraints

Figure 3



Five-Point Restraints

Figure 4

Whenever additional confinement was practiced, it was never recorded or counted as an escalation and was rather an expression of the individual staff's ingenuity in solving a problem. One method involved the tying of the ankles to each other and to both sides of the bed, which was considerably more restrictive than keeping the ankles separately attached to the side on which the limb was positioned. While, in the latter case, the leg could be moved to the extent that the length of the straps permitted, that is, usually from the center of the bed to the edge or over the edge of the bed with some movement at the knees, when the ankles were tied together, neither movement from side to side nor flexion and extension of the knees were possible. Anatomically, this causes a most uncomfortable alignment of the lower extremities, placing the hip and knee joints under considerable stress.

To prevent pulling out the nasogastric tube while sitting in the Gerichair, in spite of the presence of wrist restraints, a sheet would be draped in barber-cape fashion over the upper part of the body and tied at the back of the chair. To prevent pulling a Foley catheter or condom off, a sheet was draped over the lower part of the body and tied at the back of the chair and the lapboard was pushed flush against the body to limit access. To keep a urinal in position, a sheet was twisted in a figure eight around the handle and upper thigh and tied to the chair, which effectively prevented the patient from crossing his legs or moving the tied leg above the knee.

Another method of restraint, that prevented the patient from using their fingers and hands, was the application of a generous wrapping of Kerlix bandages over the fists. This approach to the prevention of tube

dislodgement was not recorded separately as restraint either, but was usually used in conjunction with the application of wrist restraints.

The shoulder loops on the Posey jackets, designed to be used for additional support while the patient is sitting in a wheelchair, were only utilized on one patient, to prevent him from pulling on a tooth while both his wrists and trunk were immobilized. The patient's depression and reluctance to communicate with the staff had led the nurse to believe that he was demented or senile and not capable of behaving in a sane, comprehensible fashion. When he made the gums bleed by pulling on his tooth, the nurse tied his shoulders to the back of the Gerichair, in addition to the wrist and trunk restraints, to prevent his access to his mouth. It seems that nobody asked this patient why he pulled on his tooth. Extraction of his abscessed tooth stopped his behavior and the pain. While the shoulder loops on the Posey jackets are intended for support, their availability can lead to an additional means to limit a patient's mobility.

Of the patients who had restraints applied, five additionally had a "sitter" around the clock to prevent self-injury. These patients were those who had been unsuccessful in committing suicide or who had a psychiatric history of threatening self-destruction or injury to others. Patients who had sitters or prison guards but were not bound by any restraints were not included in the sample nor seen as being limited in their mobility by the staff.

Having said all the foregoing, it is necessary to delineate additional factors that make it possible for a patient to become confined in restraints. The first one to be discussed is the institutional policy that provided the rules and basis for maintaining

the work order. Next, the setting is delineated as the background against which the scenario of use of restraints takes place. The condition of the patient that leads to the application of restraints is described and examples provided for the major categories observed.

The Hospital's Policy in Regard to Restraints

From the foregoing description of the work involved in caring for patients, it is evident that other factors are instrumental which make restraining practices permissible and possible. One of the foremost among those circumstances is the sanction through an institutional policy. This edict provides the mandate to restrain any patient seen to be in danger of injuring himself or of causing injury to others and for the purpose of permitting treatments when alternative measures have been ineffective (Appendix K). Since the risk a nurse takes in restraining a patient is less than if she had not done so, should the patient by prediction harm himself, it is rather surprising that more patients are not tied down than were observed.

The question of the risk a nurse can take with the patient's safety and how risk is seen and interpreted will be addressed at a later point when the patient examples are presented. However, the institutional policy states patient conditions that warrant the use of restraints. Those patients who have evidence of an altered mental status, are extremely restless, or are suicidal warrant the restriction of movement through restraint. The policy therefore makes the justification and rationale quite effortlessly plausible for any nurse wishing to confine a patient. The two exceptions to the enforcement of this policy are in

regards to the nursery, where "restraints are used in a different manner", and the critical care units, where documentation on the checklist designed for the purpose is waived.

Although the policy states that restraints are to be used "when alternative measures . . . have failed" in permitting the delivery of medical treatment and to prevent injury to the patient, no alternatives are given. While the policy specifies the necessity of a doctor's order which states the type of restraint to be used and the reason for the requirement, in practice the order usually read "Restraints PRN" and it was left to the discretion of the staff as to what they perceived as necessary and for how long the condition should be sustained.

The only contraindication to the application of restraints in the policy was in the special event of a patient in the process of having a seizure. Thus while the policy legitimizes the application of restraint, it would be absurd to suggest that the nurse would enforce the policy de novo. When entering a place of work, the new employee - no matter in which category of staff - learns very quickly the routine of the daily activities and how order is maintained to get the work done within the available time. The limits of what constitutes acceptable behavior within the setting does not become an issue, but the time it takes for an individual staff member to have reached their limit of endurance is a different matter. All but one of the nurses had either worked in a different institution or a different ward, and most had "floated" in the hospital - that is, worked on another ward when the nurse/patient ratio was too affluent a mixture. Thus they compared this to other wards in the hospital or prior institutional experiences, particularly long-term care or nursing home settings. Through such

situational comparison, models in the use of restraints were derived. Frequently statements were made in favor of their own setting in terms of the use of physical restraint, that is, they would see the ward as frugal in their application while caring for patients who were either rated as sicker, heavier, more demanding, or more difficult. It also followed that other wards were never deemed as busy or exhausting as their own. The exception to this view came from the aides and orderlies who would feel taken advantage of when floating to another area. The view of the staff as using restraints more sparingly indicates that there was no ideology for their use, that is, they did not think the devices beneficial in and of themselves. Hence there was some pride in the relative rarity of their use, by comparison. Furthermore, the restraints were seen as always appropriate to the need, while the need for restraint was defined professionally and within the boundaries set by the institution. To the question of the necessity of using restraints (Appendix D, questions 4 and 9), all interviewed nursing staff were in agreement that their use was appropriate as indicated, and in accord with their consensus. However, regarding the amount of use of restraints according to the three shifts, their use was seen as more necessary on the night shift, with the explanation that more old patients were "sundowning" at night. Only one of the evening nurses offered a divergent view and stated that "the night staff give us a hard time if we don't put an old frail patient into a Posey jacket before they come on duty, even if I don't think it is indicated".

Clinical Considerations and Patient Variables

Perceived as Warranting Restraint

Some patients, having already been judged as being too agitated, restless, or disruptive of the treatment regiment, were already delivered on admission to the ward in various types of restraint. Included in this group of patients were those who had been seizuring while awaiting admission. Patients who had a history of seizures (14%) in combination with the presenting clinical picture also had a higher propensity for being restrained as a precautionary measure.

One aspect not readily apparent in determining on what basis a patient does not become restrained rests with perceived characteristics of the patient's personality. In instances where the safety of the staff is at risk, the decision of whether or not the patient ends up in restraints hinges on the nature and urgency of the clinical scenario. The patients who stated verbally that the staff would have to kill them first or that the patient would kill the staff before they would permit restraints to be applied, remained free - if the patient presented a real threat to the staff' physical well-being and their clinical circumstances were not critical. Part of the evaluation of accepting the patient's self-determination was dependent on whether or not they accepted the medical treatment regiment.

The biographies of some patients were well known to the staff, as the patient had had multiple admissions to the setting. The staff thus had a basis for comparison and would make their decisions on past behaviors and reactions. The staff thus monitored the present course of hospitalization against previous events and decided whether or not to

restrain a patient on the composite picture of past and present behavior vis-a-vis the therapeutic regimen.

The practice of using restraints thus can be seen as a function of the setting, the policy, and the staff's appraisal and organization of their work and assessment of their patients. The restraint, for the most part, therefore can be taken as a situational decision on a problem in professional work and not necessarily as a clinical decision. The effort to maintain the institutional order - that is, the workflow and routine - combined with a general damage control to avoid litigation, investigation, blame and, most of all, more work, conditions the use of and the types of restraint.

How the urgency of restraining patients is assessed thus becomes a function of the demands on the individual staff member responsible for the care of the patient vis-a-vis the total work assignment. Other factors are previous experience with patients assessed by the nurse as being similar in physical and behavioral status and the projected consequences. Frequently the request for restraint was initiated by an aide or orderly and relayed to the nurse responsible for the care. She in turn either reported the event to the team leader or left the team leader to decide the issue. Thus the position in the hierarchy had relevance and also the relationship of the individual team members to each other. How the individual staff member was appraised by the others involved in the decision was of particular import.

These additional considerations served as conditions for judging restraints as "necessary" and validated the assessment. The data suggest that the work requirements and staff relations were more important than clinical reasons for restraint; nevertheless, clinical

reasons were almost always given to provide the rationale for their use and, when necessary, "restraint as per hospital policy" was invoked. However, while all the foregoing has relevance to the decision to use restraints, the predominant reason rests with the patient himself, which will be discussed next.

Use of Restraints for Investigational Purposes to Aid in Making a Diagnosis

When the patient's clinical picture is ambiguous, the social background obscure, and presenting behavior not readily recognizable as to what it portends, the use of restraints is more likely. To illustrate the point, one monosyllabic patient who was not forthcoming in his responses, and whose past medical and social history was largely unknown, was going to be investigated for the possibility of a head trauma. One of the procedures ordered for the purpose of investigation was for him to have computerized tomography (CT scan), in preparation for which an IV was established. The extent to which the necessity of an IV was explained to the patient will remain undetermined at this point. The patient got out of his bed to go to the bathroom and disconnected the IV. The event took place on the evening shift, which happened to be extraordinarily busy with new admissions. The IV was reestablished and the patient put into a Posey jacket. The salient features in this scenario were the unknown medical diagnosis that, from the physician's perspective, needed to be resolved and actively pursued. The patient, though passive and needing encouragement to eat his meals, presented no nursing problem until the IV was established. The necessity of the intervention was not appreciated by the patient, nor

were the precautions to keep the IV intact explained. Since the patient failed to verbalize his perspective, he was placed in restraints, much to his discontent.

The patients who found themselves in similar circumstances (21%) were generally older, with a problematic medical history, and difficulties in arriving at a diagnosis. Invariably an IV was established to provide access to a vein for the administration of medications to correct any fluid and electrolyte imbalances, and to ensure a well-hydrated patient so as to prevent adverse effects from the investigational procedures. However, by far the most frequent reason for restraint use was attributed to changes in patient behavior and deterioration in mental functioning.

Use of Restraints to Preserve the Treatment Modality

Patients under this category are generally younger and have a history of alcohol abuse (64%). Frequently, patients who have been in jail or are afraid of being put into jail fight valiantly any confinement, as their expectation of what is reasonable under the circumstances is exceeded. While the siderails are considered part and parcel of the hospital bed in this local, and are almost always raised in a patient confined to bed, the patient may well perceive them as prison bars. There is no reward built into the ward management for any staff member to explore possibilities for alternative approaches to preserve the therapeutic regimen in the most innocuous manner and beneficial to the patient.

The documented reasons for placing a patient in restraint are presented in Table 9. Combinations of the three grouping were usually

applicable. Thus a patient who got up without calling for assistance was either ordered to be on bed rest or in the process had dislodged a tube or disrupted treatment.

TABLE 9

Documented Reason for Initiating Restraints
as Stated on Nurses' Notes
(n = 42)

Reasons	Patients n	%
Conditions of Altered Mentation/Prevention of Injury		
Agitation	16	38.10
Hallucination	11	26.11
Confusion	6	14.29
Other unacceptable behavior	5	11.90
Combativeness	3	7.14
Preservation of Treatment Modality		
Disconnection of intravenous infusion	15	35.71
Pulling condom off	11	26.11
Pulling urinary catheter out	7	16.67
Pulling nasogastric tube out	5	11.90
Pulling nasal prongs or face mask off	4	9.52
Pulling rectal tube out	3	7.14
Preventative/For Patients' Safety		
Potential for falls	11	26.11
Gets up without calling for assistance	9	21.43
Weakness due to debility or paralysis	7	16.67
History of seizures	6	14.29
Wandering	3	7.14

The following account gives an example of a patient for whom restraints became necessary as he went into alcohol withdrawal, which progressed to delirium tremens.

A male middle-aged patient in fair nutritional status is admitted with a history of having a fever for a few days, abdominal pain, alcohol abuse, and lice. He has had diarrhea and vomiting for three days. He was very shaky on admission, awake and oriented, but spoke Spanish only, and it was difficult to determine how much English he comprehended. He stated he was a heavy drinker and was brought to the hospital by a friend, with the chief compliant of having lice. He voided without difficulties. An intravenous line was established (presumably in preparation of antibiotic therapy, though not stated). Within an hour of admission, a nasogastric tube and a Foley catheter were inserted, for unstated reasons. About half an hour later the patient started calling "Oscar" and seeing somebody by the window crawling with bugs. The patient received 10 mg Valium intravenously and a Posey jacket "for his safety and the protection of the tubes and prevention of self-injury".

The salient features that constitute the impetus for restraint of is patient are the inability to align the treatment regimen and all it rtains to with the patient's expectations or comprehension of what was cessary to treat lice. From the perspective of the nurse looking ter him, he became a management problem as soon as he became agitated, arted to hallucinate, and could not be trusted not to dislodge the serted tubes. From the perspective of the physician, the intravenous fusion was necessary to administer the antibiotic therapy to combat e unknown infection. The nasogastric tube was necessary to determine ether or not the patient was having an upper gastrointestinal morrhage or for the purpose of decompensation in the event of a bowel

obstruction or, since the tube was in place, to leave it there just in case it was needed later, to save the trouble of inserting another one. The Foley catheter allows the monitoring of effective hydration and alleviates the patient from the effort of urination. While the above explanations may appear as oversimplifications of the reasons behind the treatment regimen, the fact remains that no alternative approach had been considered.

Since the patient was an "unknown" in terms of his temperament, behavior, and trustworthiness, the nurse could not or would not take the risk of letting anything happen to those tubes. Furthermore, he was about seventy pounds heavier and considerably taller than the nurse, and should he have become more agitated, she was a poor match to do battle with him. Another facet bearing on the scene is that invariably (from the staff's perspective) things get busy at the change of shift, as in this case, and the night shift would expect this patient to be "Poseyed" and would be unhappy with the evening shift for not having taken care of their work, leaving things for the night shift to do. Thus, before the patient had even been seen or assessed by the new shift, on the basis of the information of the diagnosis, history, and having become noisy in spite of chemical restraints, tying him down became necessary.

Prevention of the Environment that Leads to the Use of Restraints

While the noisy disturbance of the ward is not abated through the application of a Posey jacket, at least the noise was contained within one locality. Verbal admonitions and chemical restraints were the means to control the noisy disturbance and agitation. How effectively the approach achieved the desired results was a function of the frequency of

intervention, the effect the individual staff member had on the patient, and how the latter appraised the situation.

One patient with Down's syndrome and hepatic encephalopathy, who had all four limbs and trunk in restraints, became very vocal, making gutteral sounds on recovery from a semi-coma. The nurse, making her rounds as team leader, was utterly amazed that this patient would comprehend her explanation that he would have to wait until she had finished her rounds and would then come to untie him. Although this patient was 45 years old, the staff had assessed his mental capacity as that of a 3-to-7-year-old and did not anticipate that he would comply with any requests, such as remaining quiet.

However, a noisy patient was usually perceived as a nuisance by both the staff and other patients on the ward and was rarely seen as a person whose needs were not met. Frequently the nurses would explain the reasons for the behavior as either due to the disease process or as a patient behavior problem. The noisy patient was then labelled as either confused or obnoxious, or both, as determining the reason was frequently a time-consuming task and often proved futile. One 28-year-old patient with lupus erythematosus had been crying, calling, and noisy for twenty-four hours, usually because of pain in her legs, needing a bedpan, wanting to get up, being tired, or sorry for taking the staff's time. Since she had a right-sided paralysis and aphasia, it usually took some time to run through the list of requests until determining the right one. However, because of her inexhaustible energy, she did not seem to require any sleep and her roommate became quite perturbed by not getting any rest, as did the patients in the adjacent rooms. Even the intern moved his sleeping quarters off the ward because of her distress

calls. She was moved to a single room and her cries continued. Both medical and nursing staff were at their wits end and medicated her. Because of her repeated attempts at getting out of bed, she was put into restraints and subsequently became even more agitated. When nurses were asked why this patient was so noisy, they would explain it in terms of a deterioration of her disease process, or just point to their head. A friend of the patient, however, attributed the medications combined with the staff's treatment of her as having made her into a Zombie. It was the night orderly who offered the explanation that she was scared and wanted to go to her own bed, the present bed being the third relocation within one week. Discontinuation of the drugs to calm her down and, through her friend, a coordinated visitor support provided her with constant companionship during the evening hours, when she seemed to be most vulnerable, and reversed her agitation and distress calls.

Another group of patients who were placed in restraints were those who had difficulties with their short-term memory (29%) and either could not remember the given explanations, instructions, or directions, and often times did not comprehend what was said to them or what was expected of them. For some, the time to process the given information exceeded the duration of interaction with the staff member. Some patients in this category were those capable of walking without assistance. While this independence is valued in general, combined with an inability to remember where the patient was located and an inability to find their own room or bed, the patient presents somewhat of a problem.

While the patient's wandering may be more acceptable during the day and evening shift, these patients were invariably placed in Posey

jackets and tied to the bed over night. Some patients, who were not memory impaired, had a medical history which made them a more likely candidate to be physically restrained. Included in this group were patients with head traumas, cerebrovascular accidents, and barriers to communication such as aphasia, depression, problems in enunciation, and speed of production of language. A language barrier was present in 48 percent of the patients. However, most patients had problems in more than one area, and a history of having had a fall was quite frequent in this group (24%).

An example of the latter was a young adult woman with a chronic systemic illness which resulted in her having several cerebrovascular ccidents that left her with a hemiplegia and aphasia. She had a istory of having seizures, chronic renal insufficiency, hypertension, d a visual deficit (hemianopsia). This patient encountered great stacles to making herself understood and to making her requests or shes regarding her daily activities and treatment known. Her cement in a Posey jacket or being tied to the wheelchair with a sheet nd here waist were outcomes of the patient's own efforts in getting either from the bed or out of the chair, without calling for stance and falling or having near falls (that is, somebody came to ssistance before she tumbled to the floor).

Patients unable to maintain their body positions either while g up in the chair or lying in bed (17%), or having had a fall due akness or dizziness, can be considered in this category (21%). ts under continuous chemical restraints (38%) were similarly able and at risk for restraints.

Use of Restraints Due to Muscular Weakness and Malaise

Another scenario that leads to the application of physical restraining is depicted in the following account. A middle-aged patient in poor nutritional status is admitted with a history of chronic diarrhea, failure to thrive, in alcohol withdrawal, and the presence of AIDS-related complex was being questioned. The patient was oriented in all three spheres but very tremulous. Because of the possibility of the presence of AIDS, the patient was placed in a single-bed room. The patient had an intravenous infusion to correct his dehydration and to allow the administration of medications. A nasogastric tube was inserted to rule out an upper gastrointestinal hemorrhage. A Foley catheter was inserted to alleviate the exertion of getting up to void, since the patient was very shaky, and to monitor the effectiveness of hydration. To overcome the tremulousness, the patient was given a tranquilizer every four hours.

The first night and day of hospitalization gave no indication of the subsequent necessity for restraints. Neither the risk assessment made for the fall prevention program, which is filled out on the admission of patients, nor the assessment of how acutely ill a patient and how much assistance is required, treatment and interventions carried out, provide predictive tools for the purpose.

According to the criteria for falls risk, the patient was not old enough, but even in the event that a nurse should have considered him at risk, the points this patient scored on the basis of required assistance getting out of bed and frequency or urgency in elimination, due to diarrhea and increased fluid intake, did not suffice to warrant the implementation of the outlined plan of care. However, the plan of care

was carried out and did not differ significantly except in the visible identification of fall prevention patient's name readily identified him as prone for having a fall. The other difference in the care plan was the justified application of the appropriate restraining device, and frequently of its use, once the patient was labeled as "at risk". Thus the intent to provide a safe hospitalization for the patient is accomplished by limiting the patient's mobility.

However, from a nursing management perspective, the patient was seen as trustworthy, since he talked and understood the language, comprehended what he was told, and had not exhibited any behavior which jeopardized the treatment regimen. The following evening the patient vas found up in the bathroom with the intravenous infusion disconnected nd blood on the floor. A Posey jacket was applied "for safety". While he patient claimed that he just couldn't wait any longer to go to the ithroom, the nurse assessed his condition as being no longer ustworthy and hence warranting further confinement. While the patient s assessed as being oriented in all three spheres, he was reported as tated, which was subsequently escalated to agitation and confusion. e identified as a risk to safe management, escalation of the lication of restrictive devices is common. Whether or not the raints had contributed to the patient's agitation had not entered equation, as the underlying assumption prevailed that the patient to be treated to get better. The acceptance of the necessity of the venous infusion was taken for granted by the nursing staff, and it ssumed that the patient would hold a similar perspective. While, ne nurse, the integrity of the intravenous line is paramount, the

patient most surely would prefer to make it to the bathroom in time. How the discrepancy between the two divergent priorities is resolved will be addressed at a later point.

Summary of Conditions Under Which Patients Come to be Placed in Restraints

The constraints within the institutional setting have been shown to have an impact on the application of restraints. The hospital policy has been found to be supportive of restraining practices, while not explicating support for a contrary option for the staff. The work assignment for the staff provides little slack to accommodate patient behaviors that are both taxing and time consuming. The maintenance of the medical treatment plan, the clinical condition of the patient, and maintenance of an environment which facilitated the completion of the work involved were the initiating conditions, singly or in combination, through which patients were tied down. The use of restraints for the various reasons was such an accepted practice that it failed to be recognized as problematic to the creation of a therapeutic environment for the patients. Since the use of restraints was not an issue with the staff who applied them, and the patient was not in a position to affect practice, no alternatives were sought. The application of restraints in this view becomes a matter of inadvertence.

The reasons that were offered by the nursing staff for the necessity for the continuation of restraints and the patients' responses are delineated in the following section.

The Necessary Conditions Which Kept a Patient in Restraints

Once restraints are applied, the patient becomes more vulnerable to the perpetuation of the devices for the following reasons. The work environment, as already discussed, was one of hectic activity and was focused on short-term acute care, that is, on the restoration from acute illnesses. The institutional policies and rules were used to justify what had to be done to preserve the work environment and the treatment plan that was of utmost priority was the one prescribed by the physician. Frequent shortages of staff and the presence of relief personnel or "floats", as they were called, did not provide the continuity of care necessary for a therapeutic environment for the patient. That is, the patient's baseline of functioning and any improvement or deterioration were largely unnoticed, or only noted during some shifts and not others, and not communicated to the next urse taking over the care. Thus, likes and dislikes of a patient ecame the private stock of knowledge for some members of the staff. e patient rarely knew who his nurse was on any given day, but the tients capable of remembering would usually know the name of one of m and thought her to be the head nurse or team leader, although she d an orderly's position. Even experienced nurses agreed that on ir first day returning from their day off, their work was haphazard disorganized as they weren't able to gauge how much patients could or themselves, how stable their condition was, and how long it would to carry out treatments. Asked whether the nurse would take a nt out of their restraints on their first day back at work, the r was "very unlikely". Thus, when the nurse was asked why a ular patient was in restraints, the most common answer was "It

probably is for his own safety - or his own good", and when pressed further, would state that she didn't really know him and didn't want to take any chances.

How the staff's uncertainty impacted on the patient's hospitalization is depicted in the following example.

A supposedly 90-year-old lady who neither spoke nor understood English was hospitalized with a history of diarrhea for three days. The stated admitting diagnosis identified "dehydration and failure to thrive" and a questionable "acute abdomen".

She has been staying in a board-and-care home, but had developed abdominal pain and was therefore brought to the emergency room. No bowel obstruction was found, although the abdomen was distended. Although her arterial blood gas results were within normal parameters, she was placed on oxygen via nasal prongs. An intravenous infusion was established and she received fluids at the rate of 125 ml per hour. A Foley catheter and nasogastric tube were inserted, both of which she pulled out a little later.

Since her abdominal distention resolved overnight and her dehydration was corrected, the medical team would have liked to send her home. However, in the interim the board-and-care manager would not agree to her return. Social service was consulted but could not arrange nursing home placement until the financial arrangements were sorted out. Although the patient had a left-sided weakness from a cerebrovascular accident two years before, she transferred quite easily from the bed to the chair. She looked alert but needed assistance with her meals. While she had taken off her nasal prongs repeatedly, she was not short of

breath, and whenever the nurse came back into the room she just put them back on. Later she was catheterized three times, twice unsuccessfully and the third time with a bigger-sized Foley, which was kept in place. No sooner was the patient left alone, she pulled out the Foley catheter with the bulb inflated. However, her intern did not insist on a further reinsertion.

While the episode appears innocent enough, the incident was documented and verbally reported to the night shift, as there was a potential that the trauma of pulling the inflated catheter out of the urethra might interfere with her voiding or she might have some hemorrhage. However, it also underscores the patient as a potential problem in keeping tubes in situ. During the night shift the patient attempted to climb out of bed and a Posey jacket was applied "for her safety". No reason was given as to why she wanted to get up.

The application of the restraints are the culmination of the ability to make her views, her pain and discomfort, likes and dislikes own. Her nonverbal behavior and vocalization were largely discounted irrelevant, as the clinical picture takes precedence over personal ferences. Neither her cultural mores nor her inexperience with pitalizations were facets which were made explicit. For the patient, confinement through the restraints must appear as the final assault her as a person, which she has to defend to the last. From the ent's perspective of having ruled as a matriarch over her family all life, the conduct and treatment she received by people the age of grandchildren likely did not fall within the boundaries of the nable and acceptable. Thus the use of physical restraints can be uted to a noncomprehension of each other's domain of reality from

which the participants work. From the patient's perspective, it was reasonable to try to get out of bed at night when her vocalizations for help were not answered. For the night staff, she was a confused old woman who didn't understand what was needed to make her better, as she had pulled out her tubes and pulled off the nasal prongs. Thus, as far as the staff were concerned, there was no alternative but to tie her down. The next shift taking over took no chances and maintained her restraints. Thus, while her reasons for admission were resolved within the first twenty hours, the high technological approach to care and social dependency created a situation which neither she nor the staff nor the family were able to overcome. The family would not or could not take her home, the social service could not find a placement for her, the physician maintained the intravenous and nasal oxygen, and the ursing staff continued the restraints to prevent the "treatment" from eing interfered with. Ultimately it was the patient who suffered the onsequences, as she persisted to attempt to remove the tubes and erefore was maintained in restraints for the next month, the last of r life.

The effect that family members and significant others have on the training practices depended on whether or not there was agreement on urgency of the clinical picture and the necessity for the treatment. matter of appraisal of the potential consequences are thus operative both staff and significant others. The decision is usually made on side of safety, that is, to prevent the patient from coming to harm, when the potential is nonspecific and not made explicit. While the nce of visitors willing and able to provide the necessary care for atients may have prevented the application of restraints, the

record of patients in this category has not been kept with sufficient consistency to permit a comparison.

Once the patient has been found to require restraints, it was more likely that the restrictions would be perpetuated, and a twisted logic frequently came into play. When a patient was alert and oriented on admission and no disease process could be demonstrated to exist, one would expect this patient to maintain his mental capacity. However, his mental capabilities were tied to his behavioral performance with little latitude or interpretation to see the events from the patient's perspectives. The following example is offered to clarify this position.

> This patient was an 80-year-old gentleman who had been found on the floor of his hotel room, too weak to get up on his own. His admitting diagnosis was "weakness and failure to thrive". He was found to be oriented in all three spheres and could move his extremities, but was weak. On the night shift he was found to be oriented to his name only, and a Posey jacket was applied "for his protection". The patient found the hospital "a nice place with good people" after his first night. Although the patient had been eating and drinking well, during the day an intravenous infusion was established, which he pulled out. The nurse who took care of him reestablished the IV and tied his wrist down. On the chart she evaluated him as confused and demented. Although the IV was converted to a heparin lock the same evening, the wrist restraints were continued. After the patient had been "incontinent" twice, a condom catheter was applied to "prevent skin breakdown". No indications were given to explain the deterioration in the

patient's condition. The three-point restraints were continued now to prevent the patient from pulling the condom catheter off. During the third night the patient was placed into five-point restraints because he "tried to kick the nurse", and he was continued reported as "confused, disoriented, and demented". The patient stated to the doctor that "the staff treated me roughly". Although the wrist restraints were taken off after the third day, he was continued in a Posey jacket and sitting up in a Gerichair, with a condom catheter continuously in place. On the tenth day of his hospitalization, his mental status was found to be improved, in that he knew where he was, and a day later one of the evening nurses upgraded it to oriented in all three spheres, after she had taken care of him for the third time. However, by now "the patient was unable to stand alone" and the Posey jacket was continued "for his safety".

The researcher found this patient to be polite, compliant, and riented throughout his hospitalization, but weak and frail and in need f assistance with the activities of daily living. The compliant ehavior of the patient did not prove advantageous to him, and his nquestioning acceptance of his daily activities did not raise the ossibility in his caretakers' minds that he was rather unhappy in his onfinement. Such "tolerance" was particularly noticeable in the older atients and in those who had given up the fight.

Patients who became agitated by going into alcohol withdrawal or elirium tremens had their restraints titrated according to the degree f restlessness, or what commonly was referred to as "combativeness", he number of tubes the staff saw in need of protection, and the

effectiveness of the chemical restraints. The following patient scenario was representative of this group of patients.

A 66-year-old man was admitted with a pneumonia, alcohol abuse, shortness of breath, and scabies. He was alert and oriented in all three spheres on admission. The staff found this patient not compliant with the prescribed therapy as he was on bed rest, with oxygen administration and intravenous infusions, and yet insisted on going to the bathroom to smoke. A Posey jacket was applied and, later, limb restraints; he was medicated to alleviate the agitation. The following day he was kept tied to the Gerichair and tried repeatedly to get out of his confinement to go to the bathroom. Staff reported him as incontinent of feces and oriented to himself only. His speech had become slurred, and he had developed coarse tremors. He was placed in five-point restraints until the next day. The subsequent two days his condition had somewhat stabilized and his restraints had been discontinued, only to be reapplied on the following day as he became once again agitated and restless and hallucinating. Five-point restraints were kept in place for the next two days. He continued to have bouts of diarrhea and was kept in a Gerichair and Posey jacket while up during the day. Often he could not hold on long enough to make it to the bathroom, although he would try to climb out of the chair and over the lapboard to reach it. He had developed decubiti by the thirteenth day of his hospitalization. He had hardly eaten anything in two weeks due to his delirium tremens, malaise, and shortness of breath. The Posey jacket and Gerichair routine were continued to the sixteenth day of his hospitalization.

Forty-three percent of the patients in restraints had similar experiences with variations according to the length of time they remained in a toxic state, the presence of underlying pathology and response to treatment, and initial physical status. This group of patients thus were monitored for the improvement in their condition and were expected to "come out of it" sooner or later and "to make it".

For patients for whom the staff held little hope for improvement in their condition, restraints became part and parcel of their attire, even when the initial reasons for the application no longer existed.

> One such patient had been on four other wards before he came to be admitted to the present one on the twentieth day of hospitalization. Both wrists were in restraints. He had a tracheostomy, a nasogastric tube, a condom catheter, and a rectal tube in place. Over the next week he made steady progress in mouthing words, nodding, smiling. He wrote something that looked like "take it out" on two occasions, and nodded agreement when asked if he meant the tubes. However, whenever he had enough slack in his wrist restraints, he pulled out the nasogastric tube, pulled the condom catheter off and the rectal tube out, and kept on pulling against the restraints. On the ninth day on the ward he developed an aspiration pneumonia as he had been given a liquid diet with a deflated trach cuff while lying in bed. While he had been able to eat on his own the previous day, a nurse made the observation that the patient "seemed fed up with a liquid diet and would rather have something solid". Two days later the same LVN made the observation that the patient had "taken a downhill turn and he looked more down and less responsive". The patient had been

able to support his weight when transferring from the bed to the chair and to shift his position while sitting up. Over the next two months, his muscular strength had declined to the point where he no longer moved the left extremities, and he showed little strength on the right; that is, he no longer pulled against his wrist restraints to straighten himself up while in the Gerichair nor did he attempt to reach the floor with his feet to change position or relieve the pressure areas. While the LVN was proud to demonstrate to the researcher that the patient still recognized her, by opening his eyes and nodding when his name was called, he did not show any signs of recognition to any body else prior to his transfer to a long-term setting. Although he no longer attempted to dislodge any tubes, his restraints had been in position with varying degrees of intensity throughout, in spite of the doctor's order to "use restraint as little as possible, please". When the intern tried to persuade the nurses to leave at least the ankle restraints off, they told her that "he isn't safe and gets out of bed". The furthest the patient ever got on his own was to dangle his legs over the side of the bed. To have a female intern advocating for him may have been less successful and effective than if such a request had emanated from a male colleague.

The patients admitted as social admissions or brought to the ospital by the police (6%) because they were found unable to take care f themselves were confined by a Posey jacket when in bed or when itting in a Gerichair while up. The reasons for the use of restraint as found to be associated with their wandering, getting out of bed, not inding their own room, disturbing or frightening other patients, or

being underfoot, to name a few reasons. Frequently these patients could not remember how to call for assistance and would be made to be incontinent in the absence of a regular toileting routine. Once labelled as incontinent, the patient became even less trustworthy and was evaluated as less oriented, warranting further vigilance and caution.

Of the patients in restraints, a further 6 percent chose to continue to wear the Posey jacket for the following reasons. One patient requested to be tied loosely to the bedframe and used the restraint as his rationale for needing assistance for all activities. Two patients continued to wear the jacket for added warmth, and one because "it looked pretty". Two patients wore the jacket with the zipper in front, not so they could more easily take it off, but because the reversal would get comments and reactions from the staff, which reinforced their behavior and was preferable to them than going unnoticed.

Acceleration or deceleration of restraint use was observed to be a result of a combination of the persistence of the patient's attempts to free himself, the assessment of absolute necessity for the treatment, the staff member's appraisal, and the clinical condition of the patient. Occasionally more confining devices were used on a short-time basis, usually during the night shift, as a Posey jacket or vest were not readily available. However, when the nursing staff were asked whether they thought more restraints were used than necessary (Appendix D, question 4), 70 percent said "no", 23 percent answered "sometimes", and percent stated that restraints were used when a communication barrier

existed. One nurse conceded that in the event that the restraints could have been avoided by more vigilance and more frequent checking on her patient than she would have to admit, she used the devices for her own convenience to save her a few steps. Only one nurse voiced her aversion to using restraints by saying, "Oh, I hate those things. They are so dehumanizing", while another nurse said she sometimes goes home and wonders what they were doing to their patients.

While no persistent pattern of increasing restrictions could be ascertained, more restraints were initiated during the night shift, which concurred with the staff's evaluation (Appendix D, questions 8, 9, 10), while they denied individual staff variation in the frequency of their use. The most frequent rationale offered was that patients were "sundowning" at night, with fewer staff available at night, plus the fact that group consensus existed for the necessity of restraints. One nurse stated that "the dignity of the patient is forgotten" and "there is no insight to see it from the patient's perspective". A third explained it by saying that some staff members care about their jobs but not the patients. There was no expressed censure or criticism of each others restraint practices, which probably can be ascribed to each of the nurses being too busy to observe the other's interaction, or knowing each other so well that no comments were necessary. That is, while a float nurse would be given the information as to what a patient was capable or not capable of doing, or how safe they were to be given the freedom to walk unassisted or not when the patient was received in restraints in the morning, the staff would not intervene in the same fashion when one of their own nurses took care of the patient. Thus,

frequently, the float nurse provided more opportunity for independence and freedom for the patient, contrary to what the literature suggests. However, a more complete description of what terminates the use of restraint is depicted next.

Condition Which Terminated the Use of Restraint

Of the eighty-two observed patients, 11 percent had the restraint removed after they died. Another 31 percent had the devices taken off when they dressed in their own clothes prior to discharge or when transferred to another setting. Inhouse transfers were not usually a reason for removing restraints. The largest number of patients (34%), however, were the ones whose mental and physical condition had improved, their physical strength somewhat returned to assure their safety and had shown their compliance with the treatment plan. Another 21 percent of the patients had the restraints taken off after the staff became more familiar with the patient's capabilities and behaviors and the patient had earned their trust. However, some patients had a prolonged struggle to achieve the latter and had to negotiate the term on all three shifts. The remaining 3 percent of the patients had the restraints removed once the investigation was completed or the central line catheter was removed. However, the last three conditions depicted are not mutually exclusive, and the divisions were made on the most predominant feature of the scenario. However, a more important aspect of the topic of restraints was the behavior and what the patients said about their experiences, which will be addressed next.

Patient Behaviors and Reactions to Restraints

From the recorded observation, 38 percent of the patients in ive-point restraints struggled to get out of them most of the time; nother 31 percent expressed both verbally and physically that they anted to be untied, while the remaining 31 percent accepted the onfinement, usually because of their debilitated condition. Patients n four-point restraints showed a third of them struggling against them ost of the time, another 50 percent stated verbally and physically that hey wanted to be untied, and 17 percent did not comment or were unable to do so. Of the patients who were in three-point restraints, 19 percent struggled most of the time, 42 percent expressed verbally and physically their discontent, 6 percent struggled intermittently to get out of the restraint, while 10 percent verbalized their request, and another 23 percent had accepted their condition. None of the patients in two-point restraints were found to be struggling against the restraints continuously, but 33 percent of them, both verbally and physically, expressed their desire to be untied, 23 percent were physically inconvenienced, 22 percent expressed it verbally, and another 22 percent were not observed to show any reactions. Of the patients who were in a Posey jacket or had one extremity in restraint, 4 percent struggled most of the time, 8 percent expressed both physically and verbally that they wished to be set free, 10 percent showed physical signs of their wish while 26 percent expressed them verbally, and 52 percent did not seem to mind. Efforts in determining trends in reactions to the restraints were found to be unproductive as the

plication of the devices varied with the improvement or deterioration the patients' condition and therefore affected the treatment regimen. While some patients fought the restraints and never relented, hers gave up after some time. Some of the anger expressed by the tients is depicted in the following accounts.

One patient had been brought to the hospital by the police because she had become forgetful and would allow people she didn't know to stay at her apartment. Because the staff were under the impression that they had to prevent her from leaving the ward at all cost, they applied a Posey jacket and later wrist restraints, since she slipped out of the former. When interviewing her the following day she said, "That was the worst thing I ever had done to me yesterday. They nailed both my wrists down to the bed. I won't let it happen again. It is most unfair. I don't give them any trouble."

Another patient was pleading with his absent friend to "get those things off - cut them off - those things hurt. Hmm, I may fall down, but so what?"

A third patient had been fighting his restraints along similar lines and then offered the insight that "I can't lie in this bed, that's how you get bed sores."

Another patient stated, "They treat you worse than a dog. Even in jail they don't tie you down like this. My arm is all bruised from the straps. I can't go to the bathroom. I can't stand it another minute. I should sue them for how they are treating me."

Yet another patient said that he had been "shackled or rather hobbled. They think that you have no brain. Even if you are serious and correct, they label you confused and keep you tied down."

These themes are repeated by the patients who could verbalize their iews or remember their experiences about their frustration over not eing able to move and being unable to go to the bathroom. For some, it as frightening, especially since they didn't know why, nor for how long hey would have to endure the condition, nor did they see any ustifiable reason for such treatment. Expressions of discomfort and helplessness were frequent. A patient who had never been tied down before said, "It's dehumanizing and insulting. Just because you are weak doesn't mean you are cuckoo. They keep putting me back into the jacket, and it is so tight that it chokes me. It is so humiliating."

One patient said that he had reached the end of his patience at being deprived of his human rights. It was the tenth day of his hospitalization. Thus, while some patients became indignant about their confinement and decided that they would fight against the restraints and probably derived some source of meaning from it, others felt punished because they felt that they hadn't done anything wrong. Some awaited their release with aplomb. As another patient expressed it, "There was no use fighting against them. They are stronger than any man. They are afraid I will pull the tubes out. I would be stupid to do that, as they only hurt you more by putting new ones in again."

Finding themselves tied down, some patients expressed a feeling of infantilization. As one said, "We used to do that to kids." Another stated, "You feel so enclosed when you are in one of those things

(Gerichair). No wonder a child rebels when they are in a playpen." A third had stated that even when her son was bad, she never treated him like that. She expressed her feelings of despair, saying, "I never thought that you would feel so helpless without your hands." However, she was also one of four patients who was able to persistently slip out of her restraints. She said, "If you tied me up with chains, I would try to get out."

Some patients who struggled to free themselves while in delirium tremens or with hepatic encephalopathy could not remember their ordeal afterwards or would see restraints as a necessary means of keeping them from hurting themselves. For example, one patient who had been struggling for eight days to free himself had become more alert and coherent by the next day but was still in wrist restraints and a Posey jacket. When questioned about it, he expressed his gratitude for having both on as "it makes me feel so much safer." However, a nurse who had overheard the conversation told me afterwards that he really was "spinning [me] a line".

One patient related that the hospital contributed to his sense of total lack of control over his own life, but that his greatest fear while in restraints was focused on "what would happen is there was a fire and I can't free myself in time to get out?" Another patient, when asked why he had slipped out of the restraints and was found sitting on the floor, said that he "was tired of being a prisoner".

The elderly patients who had problems with their vision and hearing were particularly vulnerable to being placed in restraints, as staff and patient were largely unaware of each other's frame of reference. One patient had been on four different wards before he was transferred to

this ward on his tenth day. He was agitated and noisy. His wrists were in restraints, but he had been able to pull out his Foley catheter. The nurse requested sedation for him. For the next five days he intermittently shouted that he was "stuck", that he wanted "to get out and walk" as he "wouldn't be able to do it any more" if his confinement was kept up. Two weeks after his hospitalization, his wife brought his eyeglasses as "he couldn't see a thing without them", but she kept his hearing aid at home because she didn't want it to get lost. By the following day, the patient had become quiet and was transferred to another hospital a day later.

From what the patients had to say about the use of restraints, 48 percent expressed feelings of anger, were upset, frightened, or said it was a nightmare for them. Predominantly, this group experienced the restraints as punishment, which they did not perceive as deserved. Four patients claimed they had been given "crazy pills" to comply with the treatments. Another 31 percent of the patients expressed less emphatic views and either agreed that the staff had no choice under the circumstances or that they would avoid at all cost ending up in the same predicament; however, they would be generous enough to forget the past. The latter group of patients were focused on the future and discharge, recovery, or placement to a more congenial setting. Some patients expressed the wish to go home rather than speak directly about how they felt about their confinement. For others, the disease process took precedence over other issues. The remaining 21 percent of the patients could either not remember the experience or did not feel hampered in their activities; that is, they were able to solicit the necessary assistance and accepted the necessity for this dependence on others.

Thus the congruence between the staff's rationale and patients' appraisal for the necessity of restraints was all important in the acceptance of such treatment. The explanation by the staff that the restraint was applied for their safety was seen by some patients as ridiculous and illogical, as they had not fallen out of bed in their adult life nor were they likely to fall out of a wheelchair when they were used to standing on a 30 foot ladder while painting houses for a living. However, in patients over 80 years (19%), the enforced limitation in physical mobility was more acutely perceived as a threat to their personal integrity, as their expressed desires to direct their own life were subjected to the institutional mores. Through the reduction to a passive receiver of health care, the confidence of the elderly in their ability to maintain their ability for independent functioning was seriously placed in doubt.

Summary

The acute care crisis oriented approach of the work within this setting has been shown to be an important factor in the use of restraints. The hospital policy regarding restraints has been found to be supportive of the application of restraints, while leaving alternatives unspecified. The work load for the individual staff member provided little opportunity to accommodate taxing and time-consuming patient behaviors. The commonalities for which patients were confined by restraints were found to be associated with several difficulties. One was associated with difficulties in communicating the patient's needs, either through the presence of a language barrier, confusion, or

impaired verbal ability. Another was due to a state of dependency, altered mobility, and weakness. However, most frequently, a stigmatized or devalued condition, such as alcoholism, old age, speaking a foreign language, or presence of lice or scabies was involved.

The continuation of the restraints, once applied, was found to be associated with maintaining the status quo and the nurse accepting the necessity of the restraint when unfamiliar with the patient. The element of trustworthiness was shown to be contingent upon knowing the patient and his behavior and was instrumental in either prolonging or curtailing the use of restraints. Ascending or increasing restrictions in mobility were found to be associated with patient behaviors disruptive to the treatment plan and generally were maintained until the patient became compliant or no longer required the interventions. The restraints were discontinued either when the patient was discharged, transferred, died, or had demonstrated that he was safe without such devices. The behaviors of patients in restraints was shown to be dependent on the degree of confinement, the condition of the patient, and the length of time the devices were kept in place. About half the number of patients expressed feelings of anger and agitation about their confined condition. About one third of the patients felt that the staff had no choice but to use restraints under the circumstances. Of the remaining 21 percent, the majority could not remember anything about the experience, and the others were not inconvenienced by the restraints. The findings are discussed in the next chapter.

CHAPTER VI

DISCUSSION OF THE FINDINGS

In the previous chapter, the findings were presented under headings related to the organization of the work, the views expressed by various members of the health care team, and a description of the work in terms of time management; that is, mastering the workload under conditions of scarcity and the work of the medical staff are delineated before turning to the issue of restraints. The topic of restraints has been explicated to make the distinction between what qualifies as restraint in the setting under study. An inventory of what constitutes restraint and hinders mobility is presented.

The initiating circumstances under which patients are confined, together with the reasons for perpetuating the condition and what terminates this state are depicted. The reactions and behaviors of patients to being confined by restraints have been revealed. This chapter discusses the findings presented in the previous chapter as they relate to the study questions. The findings are further examined in terms of underlying influences that shed some light onto the practice of restraining, to make it comprehensible as an acceptable treatment modality.

Environmental Factors, Equipment, Supplies, and Shortages that Impact on the Use of Restraints

In order to practice satisfactorily, nurses need enough suitable and serviceable equipment, furniture, and supplies and an environment that enhances the well-being of the patient as well as themselves. The staff in this study accommodated themselves to uncomfortable and dysfunctional architecture and perceived the setting as an improvement over the previous wards, as the present site was only seven years old. None of the nurses commented that the bathrooms were inaccessible to wheelchairs or that the only bathtub had just a narrow gap between it and the examination table and the rim could not be reached from any other point due to the storage of nonfunctioning equipment and two peritoneal dialysis machines in the same room. The bathtub was cemented on an eight-inch base, which made it easier to give a bath once the patient was in the tub but which made the ascent and descent a more risky undertaking, since the footstool was too low and a chair was too high and unstable to get in or out of. No lifting device was available and could not have been used unless the other furniture and equipment had been removed first. Thus a bath could be given only to those patients who were relatively agile and had enough muscular strength to overcome the obstacles. Only one of the patients in the study was observed to have had a bath. One of the three showers was accessible to a wheelchair, in the same room as the tub, but no shower chair was available. The metal chair which functioned in its stead was small and unstable, and the transfer from the wheelchair too cumbersome and

time-consuming. Some patients were given a shower while sitting in the wheelchair, providing a wet seat for the next occupant.

It was not the intent of this study to compile an inventory of inadequate equipment and supplies; however, the amount of time and energy required by the nursing staff to overcome these obstacles could not be ignored. The shortages of chairs resulted in a daily parade of the item between conference rooms, day room (solarium), patient rooms, and server spaces in the hallways, or for nurses when they were doing their charting. The design of the majority of chairs was particularly unsuitable for the latter purpose, since the tabletop was at the level of the nurse's chin. Frequently the arm of the chair rather than the seat was used to reach the necessary height, or a patient's overbed table was secured, if it wasn't too much trouble. While the latter item was available for each bed, this table had no drawer and most of the time was cluttered with items. Bedside lockers had one drawer and two shelves, which served to store a washbasin and bedpan or urinal, since the bathroom was not equipped for the storage of those items. There was no towel rack on either the locker or bed. Thus, once the morning care was completed, any subsequent requirement for a towel or facecloth required a trip to the clean linen cart and subsequent disposal by depositing the item in a linen-bag in the dirty-linen cart positioned at the entrance to the ward.

However, the staff didn't seem to miss what they were not accustomed to having, and comments comparing their own hospital with others were most often favorable in terms of their work. The frequent shortages or breakdowns in equipment were taken in stride and rarely

commented upon unless they presented a more than usual time-consuming interruption in their work. The breakdown of the pneumatic tube system, which happened twice during the time of observation, presented one inconvenience most nurses commented on, since all requisitions, consultation requests, prescriptions, and other requests necessitating written order forms had to be hand-carried to the respective locations. However, both medical and nursing staff felt sorely tested when the addressograph was taken away for repairs and all forms had to be written by hand. However, no matter what it was that was missing, nonfunctioning, or time-consuming, it was invariably dealt with at the expense of time available for patient care, none more so than for the patients rendered dependent through the use of restraints. The findings will next be discussed in light of previous reports in the literature on the topic.

Discussion of Present Findings vis-a-vis Other Reports on the Topic of Restraints

Katz, Weber, and Dodge (1981) gave an estimate that up to 10 percent of general hospital patients may be in some form of restraint at any one time, while O'Shea (1983) reported a 5 percent to 40 percent incidence in the use of restraints in four different hospitals with similar patient populations within one geographic area. In this study, the average number of patients in restraints varied from 13 percent to 15 percent over the two separate sampling periods, but ranged from 10 percent to 30 percent on any given day. Beyond this frequency, no

other basis for comparison was offered from the above sources. No reports have been available concerning the use of restraints within acute care general hospitals attempting to systematically depict the circumstances under which patients came to be placed in restraints. While this finding underscores the importance of the work of this dissertation, the comparison to other institutional settings and patient populations must remain tentative.

Cubbin (1970) noted that it is the availability of staff rather than the patient's condition that determines when a restraint device is used. Although there may be some support for this view, in the findings under discussion it was rather the amount of work that had to be done that would determine how long a certain patient behavior could effectively be dealt with by alternative means before restraints were applied.

Brockenshire (1985), who did a random sample of 15 percent of the residents in a long-term care setting, found 78 percent of the 600 patients in restraints. All were initiated by the nursing staff. In this study, 14 percent of the restraints were initiated by physicians, 10 percent by other wards (that is, patients were transferred to the ward in the devices), 10 percent of the patients were placed into restraints as a result of a group decision between the support staff, nurse, and team leader, and the rest were placed in restraints by the nurse responsible for the care of that patient. From the psychiatric literature, the frequency of restraints varied from 4 percent to 66 percent, reflecting a wide range in the incidence and necessity for the use of devices.

Demographic and Other Variables Impacting on the Use of Restraints

Moskovites (1984) found weekends and physical attacks on the staff to be prime factors initiating confinement. Neither of the two factors was found to be prevalent in this study, nor was there a higher incidence among women, as he identified. However, the difficulty in determining a demarcation line where the therapeutic reasons for using the devices ended has been evident in both studies and remains troublesome.

Not surprisingly, it is during the night that most of the restraints were applied in this study (43%). When the staff were questioned regarding this point, they offered the explanation that at night patients are "sundowning" and there are fewer staff members on duty. From the collected data, 2 percent of the patients wandered at night and were not able to find their own rooms. Thus the designation of the term "sundowning" is probably applied to anybody who doesn't or can't sleep at night and who wants to get up. The expectations of the night staff were for the safe delivery of any potential problem patient along the aforementioned line; that is, even when the evening staff felt it unnecessary or inappropriate to place a patient in restraints, they would yield for the sake of smooth work relations with their colleagues. Thus, not surprisingly, 31 percent of the restraints were initiated during the evening. Ten percent of the remaining patients were initially restrained during the day shift, while for another 16 percent the time of onset could not be traced from the records kept nor from verbal reports.

Newbern (1982) identified the white, older, chronically ill woman as being more prone to be singled out for abuse, particularly in the form of physical restraints. While the findings in this study did not single the Caucasian female out as far as the frequency of restraint use was concerned, this group was found to make the most persistent attempts to free themselves from their confinement. Caucasian male patients were the most prevalent (55%) in this study sample. However, congruent with the findings of Joel (1985), once restraints were applied, they had a tendency to be kept in place, for the various reasons previously delineated.

The stated reasons in the reviewed literature for placing patients in restraints varied and were more a reflection of the type of setting, the patient population served, and the type of study reporting the issue. From studies on psychiatric patients, the prevalent reasons were aggression, threats to self and others, and being out of control; from nursing homes and long-term settings, the more generalized terms employed were "to prevent injury" or "for safety", with the most prevalent threat being falls or wandering off the premises.

In the findings of this study, the most often stated reason for placing a patient in restraints was agitated behavior (38%), while the second reason was the disruption of the intravenous infusion (36%). However, the reasons why a patient had become agitated were not reported and were assumed to be known or were taken for granted. None of the nurses interviewed perceived the use of restraints as excessive, redundant, or unnecessary (Appendix D, questions 4, 5), and they were in general agreement about the conditions that warranted restraint, which was much in agreement with what had been found in their documentation.

Thus agitation, pulling out tubes, confusion, weakness, trying to get up without calling for assistance, or old age were the reasons given that precipitated the use of restraints. Only one nurse said that if she had been asked whether at times she could avoid using the devices by checking on her patient more often, then she would have to admit that the restraints were at times used for her convenience.

Schwartz (1985) identified the lack of information regarding factors which make the caregiver apply restraints at a given moment and on what the reactions of the patients are. While the conditions for which patients were placed in restraints have been depicted previously and thereby answered the first study question, the results are not entirely satisfying as they were derived from the health care provider's perspective. The scenario from the patient's vantage point depicted a divergent view. Thus, what appeared as "patient found out of bed" (21%) on the nurse's notes was explained by the patient as "I had to go to the bathroom". Sometimes the recording of the first step was omitted and the disruption of treatment was stated as the rationale for restraint. Thus, what started out as a need to go to the bathroom ended up as a disruption of treatment and resulted in the application of restraints. If the patient repeated the previous behavior, further confinement ensued.

It appears self-evident that a patient confined by a Posey jacket with his wrists tied to the bedframe would have difficulty summoning assistance. The "incontinence" that was subsequently recorded was taken as the rationale for the application of the various tubes designed to deal with the removal of wastes. The presence of "incontinence" thus led to the identification of the "potential for skin breakdown", which

was then prevented through the application or insertion of a urinary catheter or condom and rectal tube. Efforts by the patient to remove any of the tubes were reasons to apply further restraints. During the times of observation, none of the patients' "incontinence" was noted by the nurses as a significant event. From the medical and nursing admission notes, it was found that 17 percent of the patients were incontinent of urine and 7 percent of the patients were incontinent of feces on admission. The incidence of urinary incontinence rose to 52 percent, and of feces to 48 percent, after restraints were applied. Although incontinence may have been acknowledged as a sign of deterioration and debility on occasion, what was usually verbalized was the work and nuisance it presented to the staff. At times it appeared as if the patient did it deliberately to get attention or because they didn't care about themselves. However, only the comatose and severely debilitated patient made no attempt to keep a dry bed. What frequently took place was that the patient became restless and either didn't know how to get assistance or couldn't wait to go to the bathroom. By being unable to alight from the bed or chair due to restraints, the patient had little choice but to relieve himself on the spot. One patient, after having waited for an hour to be helped, replied to the orderly's comments, "Well, of course, what do you expect. I have been asking to go, and now you are holding it against me for I went."

Brykczynski (1986) called the practice of placing a patient with diarrhea in restraints "barbaric". She offered the insight that the sensory deprivation and feelings of helplessness, powerlessness, and dependence on others must be devastating to personal integrity. While for some patients the depersonalization may well have been overwhelming,

fighting against restraints and trying to get out was the thing to do to the last for others.

Rendering a patient "incontinent" through restraints has consequences beyond the personal level. First, the patient is found to be less competent. Of the twenty-two patients (52%) admitted to the hospital alert and oriented to time, place, and person, eight (36%) remained oriented while fourteen (64%) did not. To trace the sequence of events, it was found that in those patients who were not undergoing alcohol withdrawal, their recorded deteriorated mental status was related to their continence and behavior, that is, whether or not they left the tubes in place or made any attempts to ambulate. The subsequent account is presented to show this association. A patient was admitted alert and oriented in all three spheres. He had "pulled out his IV" and his wrists were put into restraints, added to the Posey jacket he was already wearing, although his IV had been converted to a heplock. During the night he was found to be oriented to his name only. He was incontinent of urine twice, and a condom catheter was applied. The night nurses reported that this man spoke and understood Mandarin only, although he belonged to her own ethnic group and was fluent in English. The three-point restraints were continued for another forty-eight hours, and he was recorded as "confused, disoriented, and demented". He tried to get up and was placed in five-point restraints. From the fifth day of his hospitalization until discharge on the sixteenth day, he was kept in a Posey jacket, in a Gerichair when sitting up, and had a condom catheter in place. His mental status had advanced to being oriented to two spheres on the tenth day and to all three on the next. He was a most cooperative and patient gentleman,

hospitalized for the first time. This 80-year-old former engineer was not accustomed to the kind of breakfast that was served in the hospital, but he was most willing to try to eat it. He found "everybody very nice", at least for the first couple of days, but by the fourth day he wanted to go home. At that point he had been in restraints for three days. After he had been in the hospital for nine days he confided to his intern that the nurses had "handled [him] roughly"; he was much relieved when a niece came to claim him on his discharge on his 17th day of hospitalization.

The rendering of a patient as "incontinent" and/or confused has implications for finding an appropriate place for that patient to stay after discharge, and thus has economic consequences. The delay in the transfer of patients to another setting is greater for patients requiring more care, and board and care facilities do not accept patients labelled either incontinent or confused. Of the study sample, seventeen (40%) patients required placement.

The altered mobility combined with the urgency and frequency of loose stools at times defeated the stated purpose for which the restraints were applied. One patient underestimated his own strength and had a fall in the bathroom, breaking a front tooth in the process. The Posey jacket was intended to prevent him from falling again. However, the urgency to defecate and the delay in extricating himself made him soil the floor, slip, and have another fall.

A risk assessment guide for the prevention of falls had been put into effect about two months prior to data collection for this study. Initially, all patients older than 55 years were assessed on admission and daily for a week, according to outlined criteria. The scoring

points which were assigned then, in turn, justified the care plan, which included the use of restraints as the nurse saw fit. After the evaluation of this assessment tool after three months, the administration decreed that all patients had to be assessed once, on admission. The decision no doubt was made on solid evidence, and a reduction of reports on the incidence of falls was probably noted. However, since neither the frequency nor the duration of the use of physical restraints was recorded, the concomitant rise in the use of restraints with the greater vigilance to identify potential patients at risk for a fall will not be known. Although forty-one (98%) patients qualified for the application of the standard care plan for prevention of falls, only eleven (26%) were documented on the nurses' notes as having been placed into restraints for having a "potential for a fall".

Patients in the study sample who had a fall were variously assessed and reported according to patient variables, the appraisal of the person who found the patient and whoever else was a witness to the event, whether or not the patient sustained any injury, and if the patient could be returned to the bed or chair without additional assistance. Thus a patient, who was seen as an unlikely witness, was reported to have been "found out of bed" or was told that he had only "stumbled" or "slipped", "skidded", or "slided" to the floor, but did not fall. What the demarcation lines were between a slip and a fall was not made explicit. However, the designation of a fall increased the work, since a report had to be made to describe the event, a physician notified, and the patient sent for an X-ray. The report of the incident was submitted to a quality assurance committee and, after their review, returned to the head nurse, who had to further investigate the incident and write

her report, often weeks later. The staff who were questioned by the head nurse expressed feelings of being blamed or put on the spot, as if the fall had occurred through their negligence. (Only the staff member's perspective on this issue was recorded.) However, on one occasion when a phlebotomist reported, at the change of night to day shift, a patient sitting next to his bed on the floor, the charge nurse reprimanded the night nurse for not tying his wrists down. The patient had been in a Posey jacket and had managed to untie himself. When the patient was asked why he had gotten up, he replied "I am tired of being a prisoner."

It was rather worrisome to the researcher to be unable to find an adequate explanation for the fact that, when the placement of a patient into a Gerichair was demonstrably more hazardous to their safety than sitting in an armchair, the nurse would persist in this practice. Various reasons were offered by the staff when questioned, but usually could be interpreted to mean that the practice helped to control the situation and assured that the patient could be found where he was deposited. The relative passivity with which the patients would tolerate their confinement was associated with the patient population being served. This issue will be pursued next, before turning to family and friends who served as advocates for the patient.

Gaining Admission as a Sign of Achievement Or As a Last Resort

Few patients in this sample came to the hospital to be diagnosed or to get rid of a disease. They came to the hospital as a last resort

when they did not want to continue their suffering, or were brought there against their own volition. However, with the high technology of health care in action, the physician did not respond to the patient's story but rather to the symptoms and investigational results. With this shift in focus away from what it is the patient tells us to an inventory of defects and abnormal findings, the reasons the patient gives for coming to the hospital at times sound quaint. Thus patients who give as their reasons for admission that they are "looking for a dime" or "it is raining outside and I need a dry place to sleep" are, as far as the staff is concerned, not in a position to know the mandated function of the hospital. On gaining admission on the basis of physical abnormalities, these patients' participation in their own care and self-determination is curtailed. While, for the patient, hospitalization may or may not be a sign of achievement, from the health care provider's view it usually is seen as a benevolent act, as the demand for beds most often outstrips their availability. One nurse stated that, for some patients, admission to the hospital is the only respite they have in their life. Only one patient in the sample was attempting to regain employment following his discharge, while all the others had no aspirations along those lines and therefore functioned under a different time perspective. However, for many people, particularly the older ones, hospitals are terrifying, either because they associate the institution with pain or death or the hospital environment is frightening and disorienting (S. Taylor, 1979). The anxious helplessness or state of depression that ensued in the older patients in restraints were in proportion to the restrictiveness of the devices and the appraisal by the patient of their necessity.

How a patient perceives his hospitalization has particular impact when restraints are applied, as this application can support the appraisal that the hospital is a hostile place or contribute to the depression or feeling of self-castigation. The nurse, under the constant constraints on her time and because of the inadequate background information about her patient, is not empowered to be an effective advocate for her charges. The presence of family or friends determined whether or not a patient was placed in restraints. The impact made by family and friends on the patient's hospital stay is addressed next.

Family and Friends as Patient Advocates

The presence of family or friends who could assist the patient and interpret the necessity for the restraints was and all-important aspect of how the hospitalization was perceived. Thus, for some patients, the restraints were seen as a necessary intervention by both patient and family, and the latter would feel free to remove the restriction while attending to the patient. Other family members or friends would become overpowered by the necessity for the gadgetry and were fearful lest anything should become dislodged or disturbed; they, too, would dictate to the patient "what was best" for them or try to convince themselves and the patient that "it was for their own good". On occasions when a loved one would be perceived as dehumanized - "but she looks like a prisoner" - or infantilized - "she said she is not a child to be tied down like this", the family member often would feel helpless to intervene for several reasons. They themselves may have felt some guilt

in not having been able to prevent the admission to the hospital. This seemed to be the case particularly when an elderly spouse could no longer provide twenty-four-hour care or when the condition of a patient deteriorated. Feelings of guilt seemed to be present also when children no longer could support their parents, for whatever reasons.

The degree to which a family member or friend could advocate for a patient was dependent upon a multitude of conditions, but seemed to have little impact on the use of restraints in the patient sample under study; 50 percent of the patients were never observed to have a visitor, and those patients who had visitors but were never placed in restraints were not included in the study. However, from the observations of nursing activities, several patients were noticed who would have qualified for the enforcement of their restraint policy. Many in this group of patients had a caring family supporter who would look after the patient, some on a twenty-four-hour basis.

In retrospect, the reason why the nurses would not solicit assistance from family members when the care of the patient was particularly problematic appeared somewhat nebulous. Not one of the many phone calls from one patient's family, for example, brought to that family's attention that the staff had been unable to attend to that patient's needs because of their inability to communicate with her and to find out the reasons for her distress calls. On the occasions when the researcher assisted a patient in restraints to make a phone call to his/her home, the staff at times would be apologetic to the family members as they could not account for how the patient could have placed the call. Somehow it appeared that the nurses were protective of the family by diffusing any demands on their time and energy, while

presenting a picture that everything concerning the patient was under control. This assumption of responsibility by the nurses was in stark contrast to the inquiry by the social worker to determine financial responsibility for the necessary care. She would point out that the patient was not just the responsibility of one family member, but that everybody had to contribute to shoulder the burden, which was usually financial.

On some occasions, the presence of restraints was not attended to by the family member, as their own distress over the patient's condition prevailed. This was particularly noticeable when the patient was gravely ill. Thus it was that after one patient had been helped to make his distress call to his home, saying "they have tied me down" in the most dispirited, plaintive fashion, that the wife, upon her arrival, did not attend to his restraints but rather pointed out that it was now up to him whether he wanted to get better or not. "I have done all I could. The ball is in your ballpark now", she said. He died the next day. Another spouse was repeatedly told by his sick wife that he was "stupid". While attending to his wife in an attempt to care for her, he could never do it to her satisfaction. It wasn't surprising that he wished his wife to remain in the hospital, in spite of the pleas from his children and from his wife to let her die at home.

For family members, too, the suffering of the patient became peripheral to their own turmoil, or was subservient to their demand that the patient be kept safe and free of the risk of injury. This finding was all the more surprising when family members could remember their own outrage over restraints half a century earlier. The daughter of one patient had been left by her parents at the hospital to have a

tonsillectomy at the age of five. Because she had attempted to follow her departing parents, she was tied down, and her reaction to this event has remained vivid and poignant for her for fifty years. When the person knowing the patient best is unwilling to share the responsibility in the risk involved, can the nurse take the chance to do so? The issue on how the nurses perceived the practice of the use of restraints and what it meant for them is addressed next.

The Nursing Staff's Views on the Topic of Restraints

The question that Burnside (1984) asked - "Are nurses taught to tie people down?" - was addressed with the first question (Appendix D). Thirty-one percent of the nursing staff had been taught how to apply restraints in nursing school, while the other 69 percent had acquired the skill through the inservice program of the hospital. Twenty-three percent of the staff had previously worked in nursing homes where most residents had been confined by restraints. Only one nurse had been in restraints herself (question 2). She had felt much more secure in restraints as she recovered from an encephalitis.

The assumption that a practice so contrary to the creation of a therapeutic relationship with a patient would persist in a nurse's memory was sought out (question 3). One nurse could remember the first restrained patient she encountered, as it was a child being held for an injection, and another one could recall the first day she had to care for two patients in five-point restraints. "I don't remember their names, but I will never forget their faces. I was so scared. I didn't know what to do. Could I remove one restraint or two or all of them? I

didn't know how to take care of them." This experience had taken place six years previously. The researcher is indebted to Seloilwe (1985) for the insight that nurses sometimes would use restraints because they are scared of the patient. However, in this study, in the two instances where the patients were a real threat to the staff's safety, they were left free.

The alternatives to restraints that the nurses perceived as available to them was addressed in question 6. Thirty-one percent indicated that medications or chemical restraints could be used, while 60 percent mentioned the use of the Gerichair and positioning the patient at the nursing station for closer observation; three nurses indicated an increase in staff and two indicated the presence of a family member as an alternative. Only one LVN indicated that the Gerichair was a form of restraint and offered her perspective that its use contributed to the decline in functional ability, particularly in the elderly patient. When the suggestion was made that a patient may be safer with a mattress on the floor, hospital policy, standards, and hygiene were invoked. "What would the visitors say?", "The staff wouldn't be able to give care", and "It would be so undignified" were some of the responses.

Since the observed practices seemed to be in the interest of preserving the order of the work and in defense of the milieu, including the treatments, the question (question 7) of how much risk a nurse can take with a patient's safety was asked. One nurse said that she used the falls risk assessment score to determine how much risk she can take, while all others stated they could take none.

To question 11 - "Do you believe it makes any difference to the patient's recovery when they are restrained?" - 46 percent answered "no". Fifty-four percent stated that the decrease in independence resulted in more work for the nurses. Five nurses stated that the patient at times became more agitated. One said that, with hindsight, one could come to the conclusion that at times the patients in restraints were not benefitted. Another nurse said she would go home at times and wonder. Some nurses felt that whether or not restraints made any difference to the patient was dependent on how oriented the patient was and on their condition.

Since the hospital policy on restraints makes provision that a sitter can be requested if the patient is still restless after one hour in five-point restraints, the nurses were asked whether they had ever requested one (question 12). None had asked for a sitter for restlessness, but 50 percent said they had requested one for patients who had been admitted for attempted suicides and psychiatric patients threatening self-destruction or leaving without the physician's permission. However, in none of the 38 percent of patients in five-point restraints who kept on struggling to get out was a sitter ever requested. One nurse offered a reason by pointing out that the sitter frequently was taken from their own support staff and hence left the other staff members with a heavier workload. An orderly gave the following explanation: "The alcoholics in withdrawal aren't in a life-threatening situation. They shouldn't have a sitter. They can have their own hangover, and the city shouldn't have to pay for it."

One nurse said she had never found it necessary to request a sitter as "none of [her] patients in five-point restraints got worse". She was

unaware of her own achievement as therapeutic agent and would err on the side of apologizing for not having done enough for her patients or for having been too stern with them. In the six years this nurse had worked on this ward, she reported that she took care of only two patients with whom she found it difficult to be polite and understanding. She felt very badly about herself, that she "couldn't get along with them and couldn't get to be nonjudgmental about them". Both patients were familiar to the researcher, and effective interaction with them seemed beyond the conventional boundaries of social intercourse.

In trying to understand why the staff would restrain a patient with such ease, the question of the legal aspects surrounding the use of the devices was posed (question 13). None of the nursing staff had known anybody who was sued for placing a patient in restraints. All agreed that the physician's order was necessary only for legal purposes because hospital policy demanded it, but that the decision whether or not a patient needed restraint was a matter for the nurse to determine. Clearly the staff saw more benefit from using restraints than from taking the risk that a patient may come to harm. That is, restraints were implied to be the lesser of two evils, and their use was reduced to a matter of inadvertence. The question of whether any patient the staff took care of had come to harm through the use of restraints (question 14) was answered negatively by 46 percent. The 54 percent who answered in the affirmative mentioned abrasions from the use of leather restraints (n = 2), edema (n = 1), bruises (n = 1), skin breakdown (n = 3) which included the development of a sacral decubitus ulcer, and one mentioned the erosion of a nostril from the placement of a nasogastric tube, that is, the patient was prevented from pulling the

tube out when it became uncomfortable. Three nurses reported that a patient had untied himself and fallen. Various dire consequences, such as strangulation, were related as having happened in other settings and institutions.

The interpretation of "harm" in relation to the use of restraints took on a different meaning from what the researcher had anticipated. The development of disuse syndromes was not noticed or were seen as inevitable as a concomitant of the patient's condition and age. To arrive at some understanding of whether or not the basis for the observed restraining practice could be found in what the staff might find as devalued conditions or troublesome scenarios, the inquiry was directed to find out who the staff perceived as their most difficult patient (question 15). Abusive patients were found to be the most difficult to take care of by 50 percent, while the manipulative patient was the one identified by the others, aside from one nurse who found the bedridden, critically ill patient the most difficult for her. Two nurses expressed their sentiments regarding alcoholics and drug abusers by stating that "they should all be lined up and shot".

What, under such strenuous conditions of work, would keep the staff working there was addressed in question 16. Several reasons were usually stated, but good working relations among colleagues was given by 77 percent. Other reasons were their independence in their professional role (31%), that is, not being the hand maiden of the physician, and finding the work exciting and self-fulfilling (23%), while one said it was the challenge of "working around the system" and another liked the routine of the work.

Related was the question of what the staff liked best about working in this hospital (question 17). Benefits, pay, and job security were the predominant reasons stated by 46 percent, while 38 percent referred to the learning opportunities and keeping up to date as uppermost; the other 16 percent stated that it was the convenience of being close to their home or that a friend or family member had recommended it. From these answers, it could therefore be surmised that the staff worked there because they chose to do so.

Results of the pursuit of the researcher to derive some understanding of the practice of using restraints did not appear any more successful. Neither the attempt to analyze the work, the constant shortages of time and resources, nor the educational preparation of the staff could adequately account for the findings. Approaching the interpretations through the specter by which the person becomes objectified will be presented in the next chapter.

Summary

The structural and environmental obstacles were briefly presented as an indicator of what demands are made on the time and energy of the caregivers. In comparing the findings to those of other studies, the frequency of restraint use fell between the quoted percentages of incidences. Neither the number of available staff nor specific days of the week were found to be associated with a noticeable increase in the use of restraints, while night time was the most prevalent time when restraints were initiated. The request for restraints was initiated by the nurses for 76 percent of the patients, while the others were either

admitted in restraints or were restrained at the behest of the physician. Agitation and disruption of intravenous infusion were the most frequently documented reasons for applying restraints. From the patient's point of view, his need to go to the bathroom initiated the sequence of events that led to the placement of restraints. The use of the assessment tool to identify patients who were prone to have a fall has been shown to be a sanctioned rationale for the application of restraints and decline in the reported occurrence of falls. The limitations in the power of advocacy of family or friends were described. Either their unwillingness to take any risks, or their acceptance of the reality defined by the facility and implemented treatment, made the person knowing the patient the best less effective in speaking out on the latter's behalf. The family members' own turmoil or grief made some of them oblivious to what was of foremost concern to the patient.

From the nursing staff's perspective, the topic of restraints was viewed as a sign of achievement in keeping the patients safe and unharmed. Expressions of some pride in the effectiveness and expertise in restraint use was evident. The majority of nurses found restraints less of a problem than taking the risk of the patient coming to harm. Consequences of restraint use were not perceived as hazardous, and only one nurse expressed her sentiments by deploring the application of such devices. The process by which normal freedoms become peripheral will be addressed in the next chapter, which may offer some insight into the findings.

CHAPTER VII

DISCUSSION OF THE FINDINGS FROM THE PERSPECTIVE OF THE ROLE OF THE BODY

The previous chapter centered around the setting, which mandated boundaries that dictated how the work was performed. The nursing staff's perspective regarding the use of restraints and the risk they can take with a patient's safety was presented. To come to some understanding of how the enforced dependency of the patient was acceptable and relatively unproblematic can be seen as associated with the way the role of the body is understood.

The Body as Territory for Health Care Professionals To Act Upon

Disease is accepted as an entity which is perceived as conquerable by the weapons of medicine. As a consequence of this view, investigative procedures become paramount in an effort to arrive at a diagnosis within the shortest period of time, while not delaying aggressive treatment lest a deterioration in the patient's condition should occur. The patient in whose body the battle takes place thus becomes neutral and uninvolved territory, and he is seen as a victim of his own biology. The constructed reality of asserting control over

nature to master it, instead of discovering the order that is there, has consequences which are not readily recognized. Through objectification of the body, the suffering becomes peripheral to what is the disease. As Baron (1985) pointed out, "In general, modern medicine takes the disease to be an anatomicopathologic fact. We tend to see illness as an objective entity that is located somewhere anatomically or that perturbs a defined physiologic process" (p. 606). By ignoring the human experience of illness and locating it in the physical world, the disease rather than the sick patient becomes the focus. This explains the observations that a patient becomes a "disposal problem" once disease no longer can be identified or a decision has been made not to treat it. Furthermore, the biography of the patient has for the most part not been recorded, even when it could have illuminated the problem at hand. The description of what the patient perceived ailed him, unless congruent with the labels used by health care professionals, has been devalued in importance.

Duden (1985) stated,

> The modern body is the result of a self-description in which we use professionally defined concepts and notions. We constantly visualize our anatomy, which literally means our dismemberment. . . . so-called self-knowledge [is gained] by constructing a body image that could now be compared to a layer-cake of texts. From this body of description and measurements and norms I can pull out any number of sheets that all fit together, although each sheet is inscribed by a different profession and each sheet defines for me a different set of needs. My needy body has become the rationale for a prolific service profession: the transmogrification of the body befits that of society, and the radical newness of modern society will be understood only when it is mirrored in the transformation of the body. (pp. 6-7)

Through the creation of professional texts, the care of a patient became decentralized with the increase in the professional services involved, but not necessarily with the participation of nurses or

patient to provide alternative insights. When the patient holds a congruent view with that of the health care providers regarding the body, the discovery of yet another deficit is not necessarily seen as a negative event, nor the intrusion into any body cavity as invasive. However, the elderly patients in this study found the chasm particularly troublesome between what their expectations of hospitals were, that is, places that help the sick and suffering, and what they experienced.

Illich (1986) explained it by pointing out "how each historical moment is incarnated in an epoch-specific body . . . the body of subjective experience . . . [and thus the] unique enfleshment of an age's ethos" (p. 5). It sheds some light on the observation that the younger patient population was more attuned to the high technological approach to managing their bodies and environment. The younger patients furthermore were more likely to be in the "repeater" or "our regular" category. Such pros had developed what Benner (1984a) termed "a cushion of experience" in hospitalization. The acceptance of the treatments and explanations they offered frequently were reflected in the language they used or the actions they took. Thus a patient would explain that he needed the "dialysis for the purpose of bacterial count reduction", or another requested to be "snaked" to obtain a sputum specimen, while many fixed their own intravenous infusion pumps and accepted them as appendages. The focus on laboratory results, which were reported by the physician to the patient or family, gave an appearance of participatory management while the ordered treatment, which in turn determined the care plan, was rather routinized.

How a patient copes with his illness is very much dependent upon the transactional relationship between his care environment and his own

appraisal. In this transactional view, the patient's context in terms of his environment, as well as the relationship between the care providers and other significant others in the patient's sphere of influence, are in a reciprocally influenced relationship. Some excerpts are presented to illustrate the divergent interpretation between the body as scientific object versus lived experience.

Duden (1985) pointed out that "the body of tradition is the embodied response to the challenge that is given by one's story and status at a precise time and place" (p. 5). The patients in the study had, to all intents and purposes, identical bodies and were measured by the same yardstick. Ricour (1986) addressed the narrative of identity and pointed out that the problem of sameness leads us astray. The identifiable becomes unnameable, but this loss of identity does not leave behind the problematic. To illustrate the point, the history of one patient, as recorded by the physician, is presented.

> This patient is an 84-year-old white female found on the floor of her hotel by a hotel manager one hour prior to admission. Past medical history: history of senile dementia over the past few years, fainting, and hysteria. It is known that the patient was a former nurse during the second World War. Admission medication: Prolixin 2.5 mg p.o. qhs; Tylenol PRN; Penicillin VK 1 gm p.o. bid; Motrin 1-2 p.o. qid for pain. Family history, social history: lives at a senior citizen hotel. Physical exam was remarkable by the absence of abnormal findings. Laboratory values chest X-ray, cerebrospinal fluid all were within normal limits, CT scan of her brain was normal for her age.

The patient was extensively investigated to rule out sepsis. The patient only complained of mouth pain and made no efforts to disturb any of the appendages she had acquired, such as nasal O_2 prongs, a urinary and rectal catheter, and IV. Although the patient was alert and oriented in all three spheres, a Posey jacket was used "for the safety of the patient" and supported by a risk assessment score of 12 (a score of above 6 is taken as the point where a nurse, in her judgment, can use restraints).

For the first four days, the patient had diarrhea. She didn't want to eat because of her sore mouth and exclaimed "Yuck" when she saw the pureed food that was ordered for her. She had left her upper dentures at home. "I never knew there were so many ways to suffering", she said. When she was asked about the soreness of her mouth, she indicated that, while it had been sore on admission, "it is raw now". Her physician was aware that she had a sore mouth but didn't think it had anything to do with the oral potassium chloride solution that she received three times a day. "You keep on telling me. But what we need is your dentures", he told her. The discomfort of her sore mouth was not documented on the physician's progress notes; thus something of uttermost concern to the patient was converted to nothing.

On the seventh day of her hospitalization she was sent to the dental clinic for a consultation. There it was noted that she had been seen on multiple occasions in the past in this clinic for her complaint of generalized mouth pain and had also been seen in a medical clinic for the same reasons. On examination, the dentist found multiple areas of minimal denture irritation, and he was "at

a loss to explain the origins of her complaints", that is, generalized sharp, burning pain. He recommended symptomatic treatment: leave the denture out, avoid spicy foods, warm water rinses, topical analgesics if they relieved the symptoms. The dentist offered among other differential reasons for "soreness of the mouth" that it may be associated with psychogenic factors.

The topical anesthetic agent did not change the patient's statements of having "an awfully sore mouth". On the fifteenth day of her hospitalization, the Prolixin was reordered as the physician felt she might be less depressed on it, and she had been receiving it prior to her hospital admission. The following day he observed that the patient had dried lips and ordered a "chapstick". Her intake over the past day had been over two liters. On the twenty-first day of hospitalization, the physician noted that her mouth pain had improved on Prolixin. On the twenty-eighth day, her dentures in place for the first time, she was discharged to a nursing home with the discharge diagnoses of 1) failure to thrive, 2) dementia, and 3) mouth pain of unknown etiology. Neither her psychiatrist, dentist, nor physician acknowledged the likelihood that her present hospitalization had been the culmination of having been placed on Prolixin. The medication produced the dryness of her mouth as one of the side effects. Denture wearers require lubrication of the mucous membranes or ulcers develop, as happened here. Because of the ulcers she was placed on analgesics, and when she returned to the dental clinic for the third time in one month, she was prescribed oral penicillin. The oral antibiotic caused her

to develop diarrhea and, in combination with her diminished intake of foods and fluids, she became hypovolemic and fainted.

Her diarrhea was not perceived as a "problem" as her hydration status was taken care of through the IV and replacement of electrolytes. Since she was very compliant, she tried to eat and drink as much as she possibly could, and it was not uncommon for her to ingest as much as 750 ml for breakfast. While not wearing her dentures in the hospital (she had arrived without them), the lesions were slow in healing; her experience of the discomfort was disproportionate to their actual size and location and therefore was difficult to account for.

As Baron (1985) pointed out, "It is as if physicians and patients have come to inhabit different universes, and medicine, rather than being a bridge between us, had become one of the major forces keeping us apart" (p. 606). Baron saw the shift in focus from the human experience of illness to the various technological facts of disease as creating "great difficulty taking seriously any suffering that cannot be directly related to an anatomic or pathophysiologic derangement. It is as if this suffering has a value inferior to that associated with 'real disease'" (p. 607). It was through the denegration of the patient's experience that suffering became a peripheral issue. Without the necessary translation of what the prescribed treatments mean to the patient, the physician is largely unaware of what is involved. The nursing staff become instruments inflicting discomfort and pain at times by their adherence to the treatment plan without bringing the consequences to the physician's awareness. While patients were under

the impression that the physician makes every effort to help them get better, the nurses are frequently seen as doing the opposite.

For example, taking a patient's weight may set up the following scenario. The bedscale required to accomplish the task performs well in the hands of a few, and at times it takes three or four people to do the job. The accuracy of the recorded weight becomes at times an issue, notably in those patients most frail and sick. The weight loss is converted into a need for more calories. A calorie count creates more work but does not necessarily result in an attempt to provide foods most palatable to the patient. The discovery of a less than optimal caloric intake at times results in the placement of a nasogastric feeding tube. If the patient pulls it out, the limb is put in restraint. When a patient perseveres and manages to pull the tube out constantly, the placement of a gastroscopy tube is considered. The point here is not to say that in each and every case of weight loss the above comes into play, but rather that there is such a reliance on the "facts" that allows no room for an alternative interpretation and approach. The patients who stops struggling is not perceived as having reached a point of hopelessness, helplessness, or despair, but is usually recognized as having taken a "turn for the worse" or "gone sour" or "given up" or "had another insult". Expectations for success of recovery do not seem a primary focus, and the impact of the routine part of the environment and circumstances escapes notice because of its everydayness.

The narrative has to be told from at least two vantage points: one from the patients' perception of what it means to them to be unable to move freely, and the second in terms of the health care professionals treating a patient's disease. The impact of the hospital environment on

a patient was not taken as an important factor and goes largely unrecognized. What the setting is missing is an adequate support for the great range of human behaviors associated with the recovery process. The erosion of the patients' confidence in their own ability to care for themselves and live independent lives is severely undermined by placement in restraints. The importance of skilled bodily performance goes unrecognized. Both the treatment and the medical script obliterate the patient's responsibilities and social behaviors.

The Erosion of Skilled Body Performance through the Use of Restraints

The rendition of the history of a patient is not taken into consideration unless it sheds light on their physical condition. The history of a patient is therefore focused upon a medical history and heard as a simple, contextless, time-bound event. The reliability of the patient as historian is frequently doubted, which increases the gulf between the way the physicians determine what needs to be done and what, from the patient's perspective, seems reasonable or fair. The trust in the high technological approach to health care negates the human meaning and what we intuitively know to be preferable in coaxing the sick back to life. To quaff a pint of orange juice seems preferable to a liter of IV, except where the former is only available in portions of two ounces per patient per day; by comparison, there is never a shortage of IV solution.

Neither the physicians nor nurses were observed to base their treatments on what would have been the most innocuous means to enhance

the recovery process, unless the patient was capable of communicating a preference clearly. It was taken for granted by the health care providers that the patient would agree that the prescribed treatments were in their best interest, if they were able to make a lucid decision. It follows that the protection of the treatment plan by the use of restraints was seen as necessary.

"To inhabit" refers to a kind of having that gives us access to material objects and allows us to treat these objects as extensions of our own body. In this view, bodily existence flows over into things, appropriates them, infuses them with life, and draws them into the sphere of daily projects and concerns. A fully inhabited world is at the same time a fully embodied world (Merleau-Ponty, 1962). A patient in restraints is no longer free to inhabit his world, as the powers of his body are enclosed within his own skin. Cutting off access to the environment can thus lead to an alienation which comes about through the failure of inhabitation and embodiment. The effect of switching patients from bed to bed, room to room, ward to ward, or institution to institution goes unnoticed as a contributory factor that makes patients more vulnerable to disorientation, confusion, and difficulties in locating their bed or room. Patients in alcohol withdrawal who were reported by the staff as making drinking movement with their hands as if they held a bottle were not seen capable of actually performing the activity, and the bodily skill therefore was not converted to the patient's advantage.

The nurses expected their patients to communicate their problems clearly and to make their demands within the limitations and restrictions imposed by the hospital. Yet patients were coping with an

illness in a strange environment, often had perceptual difficulties, and possibly some mental impairment, all of which added to their communication difficulties. Thus the itch on a nose, or any other body part for that matter that some of the patients could not scratch, was not perceived as important. It only became an issue when through using alternative means, such as rubbing the head against the pillow, one of the appending tubes became dislodged. Whether or not the patient became more dependent by not being able to turn in his bed was noted when the patient pleaded to be tied loosely, but otherwise fit into the routine of turning patients every two hours while in restraints.

The most undervalued aspect of caring for a patient was the necessity for ambulation in regaining or maintaining bodily functions. Thus patients were kept on bedrest inadvertently for prolonged periods of time, when ambulation would have been most beneficial. The evaluation of capabilities was delegated to physiotherapists, which required a consult by a physician. If the patient would or could not cooperate with the exercises within the physiotherapy department, active and passive range of motion exercises were prescribed, to be carried out by the nurses. However, such exercises were not observed to have been given, unless the movements associated with giving a bedbath to a patient could be counted as such.

Patients who had lost confidence in their own bodily functions became further incapacitated by spending their day in a Gerichair. While some patients' decline was an inevitable concomitant of their disease process, the contributory factor of physical restraint will remain speculative at this point. Disuse syndromes are recognized in both medical and nursing literature, yet were not acknowledged in this

setting. With the lack of rehabilitative concepts, a distorted view on the researcher's part regarding the function of physical restraint became apparent, especially after observing a patient - who had initially been able to bear his weight, eat by himself, adjust his bed position by pushing the electrical gadget, make attempts to communicate by writing, nodding, smiling, pushing the physician's hand away, and frowning when a blood sample was drawn - reduced to a totally helpless being. The wrist restraint of his functional arm provided him with the only exercise he had; by pulling against it he would straighten his body up while sitting in the Gerichair. He used to drum out his own tune on the lapboard. Later, when he no longer moved his arm, the hand was bandaged into a boxer-like glove, but his wrist was left free. He liked to rest the right side of his face cupped in his right hand and cross his legs while sitting in the Gerichair. The wrist restraints prevented the former, and a figure of eight sling using a bedsheet for the purpose of wedging a urinal between his legs prevented the latter. It is a moot point whether it is preferable to have the fingers free when the arm movements are restricted, or to be able to move the arm but have no fingers to grasp anything. From the staff's point of view, their ward was seen as an inappropriate place for patients who required long-term care.

Summary

The assumption that science and technology can conquer nature, that disease is nature, and disease takes precedence over illness was shown to lead to a stance whereby physicians and nurses distance themselves

from the illness experience of a patient. The medical technology associated with the treatments in acute care defines the situation. The shift in focus from the illness experience of the patient to the technological facts of disease delegates suffering to a secondary position. Indeed, from a purely naturalistic stance, suffering has no space at all. Interpreting the patient's concerns was largely ignored, as the importance of maintaining bodily skills went unrecognized. Thus the concerns centered around the maintenance of the treatments, and the treatments centered on the disease rather than on the patient's experience, ignoring what it means to be in restraints. The issue of rights and justice is discussed briefly in the next section, to illuminate how restraints can be seen as acceptable and congruent with a fundamental human right to be treated as a person.

Ethical Issues of Rights and Justice In the Use of Restraints

The acceptance of the medical model for care encourages the health care providers to focus on an aggressive treatment plan to minimize the possibility of deterioration in a patient's condition. In contrast, Schafer (1985) points out "the civil liberties model requires its adherents, when they propose to deprive someone of his or her freedom, to follow a variety of procedural safeguards. The onus of proof rests with those who would restrict liberty rather than with the person who is to be deprived of liberty" (p. 1257). While the medical model is founded upon compassion and a desire to help, the patient may regard confinement and restraint as controlling and demeaning. The essence of

maturity is to have others respect one's choices. When a "patient is labelled as incapable of rational choice, those who apply the label, as well as others, view the patient as not fully a person, and frequently the patient comes to view him- or herself as less than worthy of respect. In other words, the stigma associated with restraints tends to become internalized and so produces a diminution of the patient's sense of self-worth" (Schafer, 1985, p. 1257). When health care providers and the family overrule the wishes of the patient, he is deprived of his right to autonomy and civil liberties.

The objectification of the patient to the "facts of the disease" ignores the question of whether or not a patient is competent to give informed consent for the treatments. Since the treatments are regarded as being for the patient's benefit and the restraints necessary to maintain the interventions, the staff who apply the restraints naturally feel less inhibited than if they were purposely punishing the patient (Morris, 1968). However, when human rights are denied, do we as onlookers or participants not also feel that our common humanity is diminished? Nobody would claim the right to punishment voluntarily, for no good cause, but, as Morris points out, this right derives from a fundamental right to be treated as a person. The denial of this right therefore implies the denial of all moral rights and duties. While people do not normally value pain and suffering, an appraisal of what constitutes a fairness in punishment is involved. A patient kicking and striking out when recovering from general anesthesia would be excused while, under other circumstances the patient may be overpowered by security guards, restrained, and sedated. "When one is out to help people, there is also little sense in arguing that the burden of proof

be on those providing the help" (Morris, 1968, p. 485). However, while the issue of painful treatment can be regarded as beneficial and necessary, when the rules of conduct are unclear and the values of patient and care providers conflict, the view of what is of benefit and to whom becomes problematic. Access to the world of the suffering is not found in the anatomicophysiologic texts.

Arendt (1958) makes the point that

> The most intense feeling we know of, intense to the point of blotting out all other experiences, namely, the experience of great bodily pain, is at the same time the most private and least communicable of all. . . . reality depends utterly upon appearance and therefore upon the existence of a public realm into which things can appear out of the darkness of sheltered existence. (pp. 50-51)

Perhaps the experience associated with restraints could be delegated to the private realm of wordless wonder if it were not for the fact that it is very much a nursing intervention. "The question of how the nurse is committed to the patient . . . necessarily involves what it means to be a professional. The word profession has as its root the Latin word profitere, which means 'to declare publicly'" (Curtin, 1982, p. 97). As Curtin goes on to point out, "Taken as a whole, the performative declarations of the nursing profession commit nurses to work to improve the quality of living of those who seek or who receive their services" (p. 99). The patients have a claim upon our compassion and a right to be treated as persons (Morris, 1968). One nurse expressed her philosophy thus: "No matter what the patient appears to be now, at one time he was loved or conceived and important to someone. This for me is sufficient to remember to treat him with regard."

Yet, as repeatedly illustrated in this study, the declaration to the public through a policy which proclaims the standards that direct

the staff to serve the patients and fulfill their needs does not mean without infringement of the patient's civil liberties.

> It has been said that knowledge and skill are the foundation of professionalism; this is not the case. Although knowledge and skill are integral to the practice of a profession, the foundation of a profession consists of the performative declaration professed by its practitioners and the fidelity of the practitioner to these promises. The fidelity of the practitioner is at the very root of the relationship between the individual and the profession. Without fidelity there is no trust, and without trust the nurse cannot practice. (Curtin, 1982, pp. 101-102)

Garritson (1985) pointed out that "nursing's efforts to attain independent professional status has barely addressed the moral practice dilemmas such as the use of physical restraints" (p. 11). While the issue of individual rights have been emphasized since the 1960s, the nurse is left divided in her allegiances to both the patient and institution (p. 12). As Davis (1978) stated it, the nurse consistently confronts the "dilemma of how to maintain personal liberty in situations where its suppression can be rationalized by both the common welfare and by the individual's happiness" (p. 3). The principle of least restrictiveness sets limits on interference with an individual and thus gives priority to civil liberty. But "the clinical and legal concepts of least restrictive alternatives are linked by the notion of paternalism" (Garritson, 1985, p. 23). Whenever the health care provider's perspective prevails over what the patient would chose in his own interest, paternalism exists and the right to act unhindered is denied. While paternalism may be acceptable in situations where the patient would have agreed to the intervention, had he been able to do so, "if there is an alternative way of accomplishing the desired end without restricting liberty, although it may involve great expense,

inconvenience, et cetera, the society must adopt it" (Dworkin, 1980, p. 239).

Thus the least restrictive alternative principle derives from respect for the person, which limits paternalistic interventions. However, the conflict between rights and needs is difficult to resolve because health care providers "are not accustomed to purposefully intervening with less effective techniques" (Garritson, 1985, p. 34). As long as the use of restraints is perceived as necessary to carry out the prescribed treatments, the limitation of the patient's freedom becomes disguised under the medical issues associated with the facts of the disease.

The question of the likelihood that a patient would come to harm, which would justify the infringement on his liberty, was only debated once by the nursing staff in this study. The debate occurred during an evening when the supervisor was consulted regarding the legality of keeping a patient detained who had felt tricked by his family into coming to the hospital and who refused all interventions. From the health care providers' perspective, not to accept treatment was seen as harmful, while the patient did not accept the medical diagnosis and found the restriction of his liberty oppressive. Since the patient disagreed with the treatment, his competency to decide on his own behalf was doubted. Those who sedated the patient to a level that ensured his compliance were motivated by concern for his best interests and therefore did not perceive themselves as depriving him of his liberty. While, legally, "any patient can refuse treatment even when treatment appears to all concerned to be in the patient's best interests (Schafer, 1985, p. 1259), in practice, this right is superseded by a paternalistic

medical model which assumes to look after the best interest of the patient.

Although the paternalistic medical model evolved from the aim to help patients, based on a high level of ethical conduct, the full respect for the dignity of man has become overshadowed by medical science. While the goal of restoring the health of body and mind are laudable, denying the existence of choice and ability to make free decisions deprives the patients of their liberty. "It is useless to claim that humans must control through the application of scientific data if the data determine themselves" (Curtin, 1982, p. 53). Self-determination and autonomy should be paramount and override the utilitarian benefits that may be obtained through nonvoluntary treatment (Schafer, 1985).

The assumption by health care providers that their decisions must be given priority over the patient's choice seems to rest on a value judgment regarding the person. While the caregivers act as though the problem of applying restraints is a purely technical one which requires some discretion, they fail to recognize the ethical dilemma of depriving the patient his human rights.

The concluding chapter discusses the implications of this study, how the practice of restraining has changed over the past two centuries, and what implications the results suggest for health care providers.

CHAPTER VIII

IMPLICATIONS

The medical model as determinant for care and the treatment plan that a physician prescribes for a patient is aimed at the presenting symptomatology that brings the patient to the hospital. The medical orders are based upon the state of the art and what the agreed-upon approaches to treatment are within a hospital or geographic area. While it could be argued that the basis for some treatments cannot be supported by scientific evidence, they are prescribed based on rationality and objectivity. The assumption that a patient's illness can be reduced by reason to an "anatomicopathologic fact" (Baron, 1985) has been shown to shift the focus from the sick person to the disease. When nurses align their interventions predominantly based upon the physician's orders, without interpretation or negotiating on the patient's behalf, the patient would seem to inhabit a different world should he be unable to bridge the gap and advocate for himself. The acceptance of the medical model of disease leads nurses away from what traditionally has been the domain of nursing. Donaldson (1983) pointed out that "health and wholeness have been defined in nursing with attention to the individual's feelings, values, and personal meaning, rather than in terms of external criteria for optimum performance and function, or the absence of disease" (p. 40). It is precisely these

values, feelings, and personal meanings that have become subsumed, denied, or have gone unrecognized when the treatment plan and protection of the milieu are taken as paramount. But for whom is the treatment plan intended if not for the patient's benefit? The error is not in the treatment plan, but rather that the emphasis continually falls on the wrong place, on the disease. The patient, on the other hand, fastens his gaze upon his experience and determines whether the treatments have meaning or are completely meaningless. This simplification of what counts as real, and for whom it is of utmost importance, permits the emphasis to fall on the right place, on existence.

"Nursing's reason for being is societally, rather than intellectually, determined, with great value placed upon humanism in nursing practice" (Donaldson, 1983, p. 41). It was at the heart of humanism that the practices observed in this study struck the most discordant notes. When the social construction of reality is based on the perspectives of the health care providers and does not embrace the patients' perceptions, the suffering associated with being ill becomes a peripheral issue. Not what the patient would select as preferable, but what is seen as technologically more advanced, hence more sophisticated or expedient, is chosen for his benefit. Once the facts of the disease are taken as the focus for treatment and the role of the body is scientifically delineated, the multidimensional expressions of suffering become inadvertent concomitants of the patient's poor biology. It isn't exactly as if the patient is blamed when he does not get better with the prescribed treatments, but rather it is taken as an inevitable outcome that would have taken place sooner or later. The transience of the interns and students complicates the clinical picture for the patient,

as the continuity of care is disrupted and each new arrival on the scene establishes his own baseline. Handing the responsibility for a patient over to the next colleague through writing copious "off-service notes" leaves out the aspects that are not reducible to the various technological facts of disease. The new intern or medical student is sorely pressed on the medical service and usually maintains the status quo for the patients already "managed". The intern who ordered the Foley catheter to a straight drainage system is unlikely to get to know about the atonic bladder that was discovered two months later.

Both nurses and physicians worked very hard, but their efforts could not consistently be seen as having the desired therapeutic effect on the patients in the sample. It was as if all three participants - nurse, patient, and physician - inhabited separate domains, with the nurse and physician blind and deaf to each other's difficulties and to the patient's overwhelming unmet needs. But can nurses expect the physician to know what it entails to carry out his orders if he is not made aware of this?

Schatzman (1986) pointed out that the nurse works for the physician, but he in turn works for her, too. Thus the nurse preserves "his IV", that is, the IV ordered by the physician which was established by the nurse. The physician will order "restraints p.r.n." at the nurse's request to help her carry out "her work". The use of restraints thus is the physician's concession to the nurse, which allows her to play it by the rules or to use at her discretion. It is in the physician's interest not to disturb the ward order. The order for restraints is not the only concession the physician makes, but it sets

up the sequence previously described, whereby the patient requires the placement of tubes and further restraints.

Practical judgment cannot be prescribed by rules, nor is it the privileged accoutrement of the most highly credentialed. Would the patient truly select the most sophisticated approach to his recovery if a less expensive means would do the same and keep him in touch with himself and his environment? Yet the support staff, who most consistently observed what a patient preferred, were infrequently consulted. The information of the patient's preference did not become part of the permanent record. The realization that the support staff carried their own stock of knowledge explained a previously made observation. That is, the difference between the nurse's and support staff's reports of how they had spent their day when working on another ward as a "float" was striking. The nurses consistently commented on how easy it had been for them, as all they had to do was to carry out the treatments on their patients. They felt their workload was lighter, and they finished their work on time. They usually commented that their patients were not as "heavy" as on their own ward. In contrast, the aides and orderlies reported that their work had been so much more demanding, as they were given the "heaviest patients". On comparing the number of patients they took care of on their own and other wards, there didn't seem to be much difference.

The explanation advanced here is that the support staff, unencumbered by the professional terminology and facts associated with disease, get to know the patients as people. They interact according to a common humanity that has not become submerged by professional labels. It therefore becomes more understandable that, without the background

knowledge about their patients, the support staff would find it more difficult to look after the patients on another ward. The nurse, conjuring up a clinical scenario befitting the disease, found it easier to care for somebody on another ward because all the other demands made on her time while on her home base were lifted. She had fewer interruptions, as she was no longer expected to be a walking information center for everybody, nor was she involved in the administrative functions of the other ward.

The Changed Practice of Restraints, Then and Now

Where "reality" is composed of the themes of the professionals, the contributions of the supporting tunes can be easily submerged and can leave the physically and intellectually immobilized to struggle together, without affecting changes that would enhance the understanding of any of the participants. It is certainly questionable whether future generations will perceive the humanitarian efforts of providing care for the sick from our perspective when determining the efficacy of physical restraints (Figures 5 and 6). The debate for or against the application of such devices is reminiscent of that which was initiated by the moral management of the insane by Conolly (1856) in England. "The early nineteenth century is associated with the more humane treatment of the insane. Moral management offered the promise of cure through kindness and persuasion. Physical restraint was completely abandoned or reduced to a minimum" (Skultans, 1979, p. 102). As a result of the testimonies of the philanthropists at that time, reforms were introduced which made the erection of public institutions compulsory and the inspection of

Then - A Coercion Chair

Figure 5

Now - A Gerichair

Figure 6

all, whether public or private, compulsory. The asylums were the outcome of the public's outrage on discovery of the revolting and inhumane conditions that were endured by the insane and by the physician's newly found faith in the possibility of a cure. It was soon found that the demand for beds far exceeded their supply, and the asylums failed to fulfill their initial therapeutic promise. It was thought the reasons why the asylums were functioning badly were because of "the unpromising human material with which it had to deal and not because of any defects intrinsic to the system" (Skultans, 1979, p. 104). The prominent concern of these asylums was the security and the preservation of order within the institution. As Conolly (1856) pointed out,

> [The asylums] appear to have had regard solely to the safekeeping of the inmates, and the buildings resemble prisons rather than hospitals for the cure of insanity. Even now, high and gloomy walls, narrow or inaccessible tables and benches, and prison regulations applied to the officers and attendants attest to the prevalence of mistaken and limited views. (p. 7)

The views held about lunatics and paupers made it acceptable for the attendants to manacle and shackle those who were troublesome so that they could neither stand nor lie flat; to starve and keep them naked was standard practice and thought to be perfectly fit and proper treatment. The many committees that were formed to investigate the conditions within asylums found conditions described as inhumane, many were badly located, and there were inadequate provisions for their inmates. The lack of exercise and the practice of leaving the lunatic to pass his time listless and unoccupied, which worsened his delusions, was recognized as contributing to the creation of "incurables". The

danger of clogging up asylums with such long-term patients was seen as particularly great in the asylums for the poor.

Scull (1977) explained that "from the moment the asylums opened, they functioned as museums for the collection of unwanted . . . [and] became the dumping ground for a heterogeneous mass of physical and mental wrecks" (pp. 612, 614). This author made the point that, once institutions were erected, the public became less tolerant of what was perceived as deviance. The interpretation Scull gave to the development of lunatic asylums seems indirectly supported by a comparison with the development of general hospitals. The hospital, just like the asylum, is a place of last resort for those who cannot afford anything better.

Skultans (1979) pointed out that

> Psychiatry is permeated with social values and, therefore, its changes throughout history are, at least partly, related to changing values. . . . Human behavior only makes sense in the light of the values and rules by which it is governed and inevitably, therefore, what counts as disorder will depend upon the ideals of behavior at any one period. . . . Frequently the fashions in psychiatric diagnoses provide a clue to the personality characteristics most highly valued; the description of an illness often incorporates characteristics opposite to those of the ideal human being or a caricature of them. For example, the masturbator whose vice leads to insanity epitomizes loss of the most highly valued human attribute - self-control; excess of imagination is thought to constitute insanity at a time when reasonableness is highly valued. (p. 140).

Then as now, failure in treatment was predominantly attributed to the poor human material with which physicians and nurses had to contend. The routinization in the hospital was still seen as necessary to accomplish the work. Regimentation of the patient often made him see his confinement as a jail sentence, but this was discounted by the staff. The patient was perceived as not in a position to know what was involved in the treatments or what was reasonable within the

institution. While in the past, lunacy was closely related to pauperism, illness is more prevalent in the poor of the present. The ability to classify cases in the past had as consequence that treatment was directed to the categories of disease. Identification of disease directing the treatments now has shown to do the same. That is, the medical technology that comes to define the disease takes on a life and reality of its own (Baron, 1985). Then as now, society has delegated the responsibility for those injured or unable to care for themselves to a place such as a public hospital for cure. Then as now, a patient loses his individuality once he becomes a member of the setting, which is put together to maintain order and regularity, with routines serving the efficiency of the institution. Then as now, as institutions grew in size individual attention gave way to increased regimentation and the use of physical restraints.

The Next Step

This study has found the application of restraints as practiced in the setting to be a complex and troublesome issue. Expert opinion has come to override the vernacular of the patient's experience when the social construction of bodily reality is left to one agency, that is, medicine. Nurses, by accepting the prescribed treatments without interpreting and advocating for the patient, leave the latter vulnerable and hardly in a position to speak up on his own behalf when his behavior gives rise to the application of restraints to begin with. The press of the actors involved at the grass-roots level makes it almost impossible for them to be capable of genuine creative responses when the necessity

of the present holds them in their grip. It is not surprising that restraints, rather than being applied as a last resort, are the practice which allows the treatment plan to be carried out. Alternative approaches to the use of physical restraints can only be worked out as a cooperative venture, involving all who take part in the delivery of health care. However, others removed from the clinical setting cannot become aware of something they do not perceive as a problem, much less the extent of their involvement.

The hospital was built to serve the patients and to create a workplace that was intended as an improvement over the old structures? It is doubtful that either the clientele it serves or the staff working at the bedside were consulted as to what would be an improvement over the old site. While the large wards were seen as archaic, the isolation of the one- and two-bed rooms and the associated difficulties in monitoring a patient's condition were probably not anticipated.

The contractor who installed windows that permit the wind to blow through the room is probably unaware of the discomfort it causes the patients when it is cold. The electrician who attached the lights is probably unaware that the patient's sleep is being disturbed by the nightlights overhead, or that the call system is inaccessible to some. The committee deciding on the purchase of the equipment does not see the daily hassles at the bedside. The person hiring the staff cannot possibly keep in mind the physical statures needed to accomplish the physically taxing work.

The nurses in this setting felt their value was underestimated by the administrative staff. Whenever they were promised an improvement in their duties, they ended up with more work. Too much emphasis on

independence as a discipline has blinded us to the importance of interpreting the patients' experiences to the physician who writes the orders for treatment. Nurses are experts on suffering, but how can it come to be known when the patient remains only a diagnosis? How can the nurse advocate for the patient if she is left without support and reward for her efforts? Both patients and nurses need to be unrestrained by fears in order to participate in a common humanity. The patient is not just the responsibility of the nurse, he is everybody's concern. The taken-for-granted world of nursing in practice presents a chasm between the existing norms of what should be done and what exists in a setting such as the one studied. The gap can be bridged, through discourse and involvement, restoring a sense of dignity and new hope to both patients and nurses in the clinical setting. For caring, comfort, and healing to be more than mere rhetoric, the clinical scene as the core of nursing cannot be abandoned. The use of physical restraints on patients is too important an issue to expect those who are the least prepared to have to address it. The highly technological approach to health care delivery programs both patient and nurse into conformity with the logic of its system. To the degree that we allow this to happen, we in academe are also becoming submerged by the reality and sacrifice the reason for our existence.

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APPENDIX A

LIST OF PATIENTS' ADMITTING DIAGNOSES

LIST OF PATIENTS' ADMITTING DIAGNOSES

Identification Number _____

901 Fever, possible bowel obstruction, alcohol abuse (EtOH'er)

902 Meningitis, possible subdural hematoma, myasthenia gravis, EtOH'er

903 Loss of consciousness, pneumonia, decubitus, EtOH'er

904 Pulmonary edema, hypertension, diabetes, EtOH'er, intravenous drug abuse (IVDA)

905 Dehydration, chronic diarrhea, failure to thrive, rule out Aids Related Complex, EtOH'er

906 Septicemia, pneumonia, hip pain, IVDA

907 Diarrhea, chronic obstructive pulmonary disease, arterial insuffiency, EtOH'er, gangrene both feet, seizure disorder, psychosis

908 Dehydration, failure to thrive, metabolic acidosis

909 Pancreatitis, liver disease, non-ketotic diabetic acidosis, ascitis, EtOH'er

910 Hepatic encephalopathy, upper GI bleed, esophagitis, esophageal varices, ascitis, thrombocytopenia, renal failure, burn (L) leg, venous stasis, dermatitis, EtOH'er

911 Pneumonia, EtOH'er

912 Systemic lupus erythematosus, nausea and vomiting, hypertension, strokes, history of seizures, chronic renal insufficiency

913 Rectal bleeding, cirrhosis, anemia, icterus, portal hypertension, metabolic acidosis, orthostatic dizziness, EtOH'er

914 Seizure, probably EtOH withdrawal, EtOH'er

915 Syncope, anemia, orthostatic hypotension, lice, scabies

916 Pneumonia, cellulitis (R) arm, COPD, atrial fibrillation, psychotic depression, EtOH'er

917 Pneumonia, EtOH'er, pulmonary tuberculosis

918 Gastrointestinal hemorrhage, cirrhosis, ascitis, abdominal pain, EtOH'er

919 Decline in mental status, Wenicke's encephalopathy, hiatus hernia, EtOH'er

920 Seizures, EtOH'er

921 Nausea and vomiting, gastrointestinal bleed, pneumonia, EtOH'er

922 Renal failure, congestive heart failure, old cerebrovascular accident, hypertension

923 Back pain, pneumonia, old cerebrovascular accident, C4-C5 fracture of anterior spinous ligament, COPD

924 Dehydration, cardiomyopathy, congestive heart failure, pneumococcal meningitis, sepsis, pulmonary emboli, EtOH'er, IVDA

925 Abdominal pain, vomiting, diabetes mellitus, EtOH intoxication

926 Pneumonia, meningitis, EtOH'er, old cerebrovascular accident with left-sided weakness

927 Failure to thrive, dehydration, dementia, syncope, cerebrovascular accident, EtOH'er

928 Chronic obstructive pulmonary disease, pneumonia, anemia, EtOH'er

929 Status epilepticus, laryngeal carcinoma, old myocardial infarction, hypertension, diabetes mellitus, EtOH'er

930 Dementia, atrial fibrillation, placement

931 Stomach pain, cirrhosis of the liver, hepatic encephalitis, intravenous drug abuse, EtOH'er, ascitis

932 Disorientation, failure to thrive, atrial flutter, EtOH'er

933 Weakness, fever, pneumonia (pneumocystis carinii), Aids Related Complex

934 Intravenous drug abuse, fever, chills, chronic liver disease, ascitis, edema, EtOH'er

935 Alcohol withdrawal, seizure disorder, back and leg pain

936 Alcoholic dementia, arthritis, pain (R) arm, placement

937 Lung carcinoma, placement

938 Rule out sepsis, change in mental status, diarrhea

939 Pneumonia, possible meningitis, fever

940 Prostatic carcinoma, urinary tract infection, decreased mental status

941 Tylenol overdose

942 Failure to thrive, weakness, xerosis

APPENDIX B

STAFF PROFILE

STAFF PROFILE

Identification Number: Date: Day:

Demographic Information

Age:

Sex: (1) Male

(2) Female

Ethnic Background

(1) White

(2) Nonwhite

Language(s): Spoken _____

Understood _____

Occupational Preparation

(1) Diploma _____

(2) Associate Degree _____

(3) Bachelor of Nursing _____

(4) Masters Degree _____

(5) LVN _____

(6) Aide or Orderly _____

Length of Employment _____

Length of Employment at Present Site _____

Years of Graduation _____

Present Position _____

What are your career plans? _____

_____

_____

APPENDIX C

PATIENT PROFILE

PATIENT PROFILE

Information Number: Date: Day:

Demographic Information

Date of Admission: _____ Date of Discharge: _____

Age: _____ Previous Hospitalizations: _____

Sex: (1) Male Year of Last Hospitalization: _____

(2) Female Religion: _____

Ethnic Background

(1) White Language(s): Spoken _____

(2) Nonwhite Understood _____

Sensory Disorders

Vision disorders	Yes _____	No _____
Hearing problems	Yes _____	No _____
Taste disorder	Yes _____	No _____
Smell disorder	Yes _____	No _____
Touch disorder	Yes _____	No _____
Balance disorders _____	Yes _____	No _____
Gait disorders _____	Yes _____	No _____
Digestive disorders _____	Yes _____	No _____

Dentures
P/C

Ht: _____ Wt: _____
HR: _____ RR: _____ BP: _____
Hbg: _____ Temp: _____

IV: _____ Reason: _____
NG: _____ Reason: _____
NP: _____ Reason: _____
Foley: _____ Reason: _____
TF: _____

Medications: _____ _____
_____ _____
_____ _____

Medical Diagnosis: Primary _____

Secondary _____

Reasons for Admission: _____

Operational Factors:

Ratio nursing personnel to patients on unit: _____

Higher than average registry use: Yes _____ No _____

Type of Restraint: _____

Who Initiated Restraining: _____

Time of Day: _____

Bed Rest: _____

BRP: _____

Up in Chair: _____

Length of Time in Restraints: _____

APPENDIX D

GUIDE FOR INTERVIEW

INTERVIEW GUIDE

1. Who taught you the use of restraints?
2. Have you ever been confined in restraints yourself?
3. Can you remember the first patient whom you had to tie down?
4. Do you feel there are more patients in restraints here than necessary?
5. How do you decide whether or not to use restraints?
6. What alternatives to restraints are available to you?
7. How much risk can you take with a patient's safety?
8. Do you think that there is a difference in the use of restraints on the three shifts?
9. Do you feel that some staff members are using restraint more than others?
10. How do you explain it?
11. Do you believe it makes any difference to the patient's recovery when they are restrained?
12. Have you ever requested a sitter for an agitated patient in restraints?
13. Have you ever known a staff member to be sued for using restraints on a patient?
14. Has any patient you took care of come to harm from the use of restraints? Can you describe it further?
15. Who are the most difficult patients for you to care for?
16. What are the best aspects of working on this ward?
17. What do you like best about working in this hospital?

APPENDIX E

NURSING RESEARCH COMMITTEE

NURSING RESEARCH COMMITTEE

I have reviewed the Nursing Research Committee's stipulations/ recommendations and agree to implement the following:

1. I will meet with the staff to discuss the following:
   a. Introduction of researcher to evenings/nights
   b. Introduction to "Field Studies"
   c. Purpose of the study
   d. Consents - Experimental Subject's Bill of Rights
   e. Level of research participation in patient care
   f. Data collection process - availability of field notes.

2. I will document when I will be on the unit by way of a log that will be posted. I will also verbally communicate shift changes to the staff.

3. I will utilize patient profile data in the context of the narrative study and not for correlative purposes. Also, data collected in this section will not be limited to categories listed and will be reflective of the hospital's patient population.

4. I will draft a verbal consent statement that will include a Statement of Intent from the Patient's Bill of Rights. This statement will be read to each prospective participant. Each verbal consent obtained will be witnessed and documented. I will log patient's name, date, time, and witness signature.

5. I, if unable to obtain a verbal consent from a patient or legal guardian (i.e. confused patient), will not use this data.

6. I will utilize an interpreter to obtain a verbal consent when the patient is non-English-speaking.

7. I will attach an Experimental Subject's Bill or Rights to each staff consent form.

8. I will share study findings with the staff.

9. I will take four months to collect data.

APPENDIX F

CONSENT TO BE A RESEARCH SUBJECT

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

CONSENT TO BE A RESEARCH SUBJECT

Erna Schilder, a Doctor of Nursing Science candidate at the University of California, San Francisco is studying the practice of the use of physical restraints of patients in acute care settings. To do the study, she needs information about the individual's personal experience with the practice from the perspective of the provider of nursing care.

I agree to be interviewed by Miss Schilder, to share this information at a time and place that is convenient to me. I am agreeable to be observed in my nursing activities.

Confidentiality will be maintained as much as possible under the law. Data will be coded and the identity of each individual will be protected. Participation in this study is voluntary. Should you decide to withdraw your consent or discontinue participation at any time, you are free to do so without any consequences.

Should you agree to participate in this study, please indicate by signing below. A copy of this consent form will be given to you. Should you have any questions in the future, please contact Erna Schilder (415) 661-2543.

Erna Schilder, RN, MA

Doctoral Candidate

Signature _____ Date _____

UCSF CHR #944208-01 Sept. 23, 1985

APPENDIX G

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

The rights below are the rights of every person who is asked to be in a research study. As an experimental subject, I have the following rights:

1. To be told what the study is trying to find out.
2. To be told what will happen to me and whether any of the procedures, drugs, or devices is different from what would be used in standard practice.
3. To be told about the frequent and/or important risks, side effects, or discomforts of the things that will happen to me for research purposes.
4. To be told if I can expect any benefit from participating and, if so, what the benefit might be.
5. To be told the other choices I have and how they may be better or worse than being in the study.
6. To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study.
7. To be told what sort of medical treatment is available if any complications arise.
8. To refuse to participate at all or to change my mind about participation after the study has started. This decision will not affect my right to receive the care I would receive if I were not in the study.

9. To receive a copy of the signed and dated consent form.
10. To be free of pressure when considering whether I wish to agree to be in the study.

If I have other questions I should ask the researcher of the research assistant. In addition, I may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. I may reach the committee office by calling (415) 666-1814 from 8:00 am to 5:00 pm, Monday to Friday, or by writing to the Committee on Human Research, University of California, San Francisco, CA 94143.

Call 666-1814 for information on translations.

APPENDIX H

INFORMATION SHEET

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

INFORMATION SHEET

A study is being done by Erna Schilder, doctoral student at the University of California, San Francisco, School of Nursing, to learn more about the use of physical restraints on patients in acute care settings. I have been invited to be in the study as my views and ideas are valuable to the interviewer in understanding what being physically restrained means to me or my relatives.

If I verbally agree to participate, I will be informally interviewed by Miss Schilder and observed in receiving care or visiting with relatives.

In answering the questions on the use of physical restraints, my answers will be kept confidential. The interviewer will separate my name from the answers and will keep my name coded and locked so my confidentiality will be protected as much as possible under the law.

Although there is no direct benefit to me from participating, the interviewer hopes to learn more about the experience of being physically restrained and what it means to relatives, which knowledge may help nurses and other health care workers to understand the practice and to benefit future patients.

The study has been explained to me. However, if I have any other questions I may contact Erna Schilder on the ward or at (415) 661-2543.

I have received a copy of this information sheet. I know that my participation in the study is voluntary and that I have the right to refuse to participate and the right to withdraw from the study without any consequences. I just have to say so.

Approval #944208-01

APPENDIX I

VERBAL CONSENT STATEMENT

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

VERBAL CONSENT STATEMENT

(Name), you have been told about the study I am doing about patients who cannot freely move about because they are tied down. Would you be willing to give your agreement in answering some questions? You know that you can ask any questions concerning the study both before agreeing to be involved and during the course of the study. Your permission or refusal will not make any difference to your care or stay on this ward.

APPENDIX J

RECOMMENDED APPLICATION GUIDELINES

RECOMMENDED APPLICATION GUIDELINES

Posey Sleeved Jacket

Application: Wheelchair

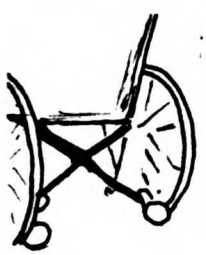
1. Select the appropriate size of restraint.

Size	Color	Weight
Small	Pink/Red	to 120 lbs.
Medium	Green	120-170 lbs.
Large	Yellow	160-210 lbs.
X-Large	Blue	200 lbs. and up

2. Insert the patient's arms through the armhole and zip the back completely.

3. Adjust the side ties for comfort and fit. Do Not tie knots.

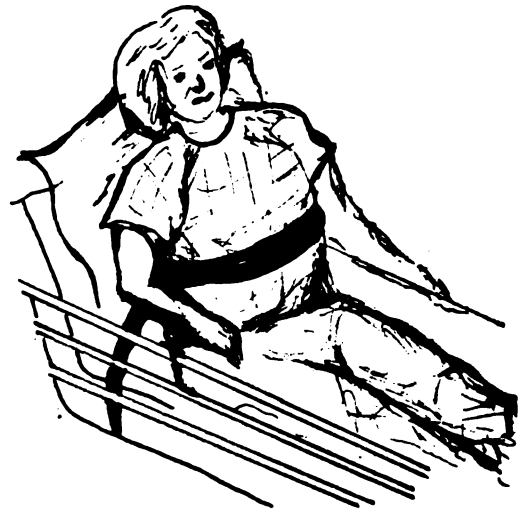
4. Attach straps to kick spurs: Thread the straps through the seat of the wheelchair and side frame. Bring the strap to the back of the wheelchair and criss-cross straps before securing to the kick spurs. Adjust the straps snugly, but allow enough room for the patient to breathe comfortably. You should be able to put four fingers between the strap and patient - open palm.



5. For added security and postural support, thread a strap through the shoulder loops and attach to the handles on the wheelchair. (To attach to a Gerichair, thread the strap through the shoulder loops and secure around the back of the chair.)

Posey Sleeved Jacket

Application: Bed



1. Select the appropriate size of restraint.

2. Insert the patient's arms through the armholes and zip the back completely.

3. Adjust the side ties for comfort and fit. Do Not tie knots.

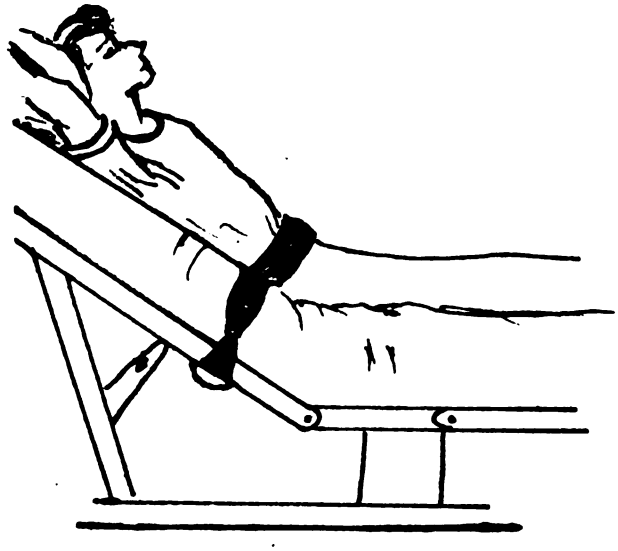
4. Attach the straps to the D-rings on the adapter strap. Do Not attach directly to the bed frame.

   Pull the straps directly to each side of the bed. Bring the straps through the back side of the D-ring and secure. Do Not angle the straps toward the head or foot of the bed. If the patient slides up or down in bed, the straps will loosen.

   Adjust the straps snugly, but allow enough room for the patient to breathe comfortably. You should be able to put four fingers between the strap and patient - open palm.

5. The side rails must Always be up when using restraints in bed.

6. Never use shoulder straps in bed.



APPENDIX K

NURSING POLICY

NURSING POLICY

Title: Restraint of Patient by Physical Means

Statement of Policy

Physical restraints will be used when necessary to prevent injury to the patient or others, to assist with the delivery of medical treatment and when alternative measures to accomplish this purpose have failed.

1. A patient will be placed in restraints on the written order of a physician. The order must specify the type to be used and the reason for application.
2. The Registered Nurse is responsible and accountable for the ongoing assessment of the need for restraints, for the supervision of their application, and for the provision of monitoring of the patient, along with necessary documentation.
3. If restraint placement is deemed urgent, as in the case of highly agitated or extremely labile patients, the Registered Nurse may restrain a patient and then call the physician to review the situation and order restraints if appropriate.
4. A restrained patient will be checked at least every hour, with more frequent checks performed at the discretion of the RN. These checks shall include evaluation of circulation of the restrained part and of the security of the restraints as well as the maintenance of the bed in the lowest position, with siderails up and padded as necessary. The performance of these restraint checks

may be delegated to other nursing team members. Note: Nursing personnel may determine the height of the bed and the use of siderails while attending the patient, otherwise when the patient is left unattended the bed is to be returned to the lowest possible position with the siderails up. Critical Care Units are exempt from the height of the bed restriction because of their staffing ratio and the monitoring equipment.

5. Restraints will be removed at least every eight (8) hours. When restraints are off, skin care is given and condition is noted.

6. Situations that require notification of the physician for re-evaluation of the patient include, but are not limited to, those in which:

   a. patients have removed their own restraints two times in eight hours,

   b. patients have exhibited increasing agitation,

   c. patients whose behavior has become disruptive to the ward, in spite of remaining restrained,

   d. the patient and/or family want the patient released from the restraint, and

   e. restraint orders that do not include PRN in the order.

   Medication is a possible alternative or adjunct that the physician may add to the medical plan.

7. If five-point restraints are required (i.e. all four extremities and a chest restraint) and the patient continues to be agitated for one hour, a sitter will be assigned to the patient. Under no circumstances will a family member be considered a sitter.

8. Please note: Leather (buckled) restraints are available for use on the floors and are to be used in extreme emergencies when routine measures have proved unsuccessful in restraining and protecting the patient and when there is a specific physician order.
9. For the use of locked leather restraints, refer to Psychiatry Policy for Restraint of Patient. Note: Locked leather restraints may not be used on any floor other than psychiatric.
10. Restraints must be easily removable in the event of an emergency.
11. The Registered Nurse will assess the patient condition for safe transport. This assessment will include, but not be limited to, the assessment of (i) airway status, (ii) blood administration, (iii) need for sedation/pain management, (iv) patency of chest tubes and IVs, and (v) the need for continuous supervision. The RN will consult with the Charge Nurse and/or physician if the need for continuous patient supervision is established.
12. When a restraint order does not include a PRN order, the nursing personnel will notify the physician before removing the restraint.
13. When using two-limb restraints, care should be used to avoid securing both limbs to the same side of the bed.

Relevant Data

Physical restraints are devices made of cloth or leather especially for the purpose of restricting the movement of a patient.

Indications

Examples of type of patients include, but are not limited to, those with altered mental status, those who are extremely restless, and those who are suicidal.

Contraindications/Exceptions

The Nursery is exempt from this policy because in this area restraints are used in a different manner. Critical Care units may document restraint check and evaluation of patients on the Critical Care Flow Sheet.

Restraints will NOT be applied to patients while seizing.

Equipment	Obtained From
Posey chest restraints	CPD
Posey limb restraints	CPD
Buckled leather restraints (without locks)	CPD
Mittens	CPD

Procedure

Nursing Action	Rationale/Precautions
1. Explain to the patient and significant others the reasons for the application of restraints.	To elicit cooperation, minimize anxiety, and prevent misinterpretation.
2. Apply the restraint allowing whatever movement is possible, while achieving the desired effect.	Tight application of limb restraints can restrict circulation. Improperly applied chest restraints can impair respiration.

3.	When an IV is running in any extremity, use caution in applying restraints.	An improperly applied restraint can cause infiltration of an IV as well as alteration of the infusion rate.
4.	Attach the restraints securely to the bed frame or D-rings or the chair. (Avoid the siderails.)	If the restraints are attached to a movable object (bed rail or IV pole), the patient can be injured when the object is moved.
5.	Restraints must be used with standard hospital beds, wheel chairs, Gerichairs, cardiac chairs, and guerneys, only.	
6.	Temporary restraints, defined specifically here as mitten or those restraints used temporarily to help physically unstable patients stay in a chair, and/or to remind forgetful patients not to move the arm in which there is an IV, may be initiated as a nursing order.	Some patients who are oriented and cooperative may need physical assistance to stay in a chair. Documentation of the use and assessment of temporary restraints is made in the nursing progress note; <u>a restraint checklist is not required</u>.

7.	Check the patient at frequent intervals. (See Restraint Checklist.)	Make sure the restraints are not restricting circulation, respiration, or causing undue discomfort, that they are still applied in the desired manner and are still indicated.

Documentation

Recording of restraint checks will be made on the Restraint Checklist which will be supplemented by a narrative note in the nursing progress notes as needed to document the reason applied, skin care, and pertinent observations.

The nursing care plan shall reflect that restraints have been or may be applied and the resultant nursing care/interventions appropriate for that patient.

Record notification of physician for any problem or for any clarification sought regarding patient care. Record also the time, the reason, and the action taken.

Date Adopted: June 1, 1984

Revised: September 24, 1985