Restraint can be justified

Sir,

No one can disagree with Dr Hughes' statement (vol 69(9), 2008, p. 494) that 'restraint has the potential to infringe people's human rights'. But does that imply it should never be used? Restraint is not inherently wrong if it is for the benefit of an individual who consents to its use. In everyday life, we are used to being restrained by seat belts in cars. In health care, constraint therapy (restraining the unaffected limb of a hemiplegic stroke patient to expedite recovery of the affected arm) is accepted in certain units, and does not raise ethical issues.

If a patient is unable to consent to the use of restraint through temporary or permanent brain disturbance, a case can still be made for its use so long as it is clearly for the benefit of the patient. Thus although it would not be justified to use physical or pharmaceutical restraint to sedate a resident in a care home, in other circumstances restraint may be justifiable to provide necessary treatment. A patient who cannot consent to treatment is not necessarily debarred from receiving it, so why should this principle not hold when considering restraint, if it permits treatment which would not otherwise be possible.

Dr Hughes asserts that there is a risk that vulnerable patients may be 'treated differently and have their human rights ignored' by the use of restraint. If restraint were to be disallowed merely because a patient was unable to give consent, and if that led to necessary treatment not taking place, then surely that would constitute inequitable treatment. It is not the act itself but the reason for the use of restraint which determines whether it is ethically justifiable.

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Sir,

I do not argue against the use of restraint as there will inevitably be cases where restrictions on someone's freedom are required in his/her own best interests or to prevent harm. What I do contend is that restraint should be the last resort.

Dr Behrman reminds us of the mental capacity issues, both legal and ethical, relating to restraint. Mental capacity legislation says that restraint can be applied whether or not someone resists and the use of restraint should be proportionate to the risk of harm. As far as possible individuals should be enabled to make choices for themselves, using advocates where necessary.

Staff need the competence and confidence to work within the mental capacity framework, especially as it relates to restraint, because reports continue to find inappropriate use of restraint. For example, an internal inquiry at Harrow PCT (2008) found 9% of patients admitted to an elderly care ward had been inappropriately restrained. Staff tried to ensure the safety of people at risk of falls using bedsheets, braces and wheelchair straps – offering the right reasons but doing the wrong thing. Conflating safety with restraint fails to recognize the serious compromises restraint can have on clinical outcomes as well as on people's dignity and respect. We need to examine critically the act of restraint and the reasons for its use.

Rarely do staff intend to cause deliberate harm or distress when using restraint. However, a lack of focus on person-centred care, inadequate staffing, poor skill mix, insufficient training and inadequate leadership culminate in the routine and inappropriate use of restraint. Restraint tends to be used more frequently with certain groups, including frail older people, those with complex needs and learning disabilities. I make no excuses for my earlier statement that some people are at risk of having their human and civil rights ignored.

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Harrow PCT (2008) The Use of Restraint on Fletcher Ward. www.harrowpct.nhs.uk/uploads/SUI_Executive_Summmary_Final_5_Sept08.pdf (accessed 13 October 2008)

Unfractionated heparin nomograms: are we following the evidence?

Sir,

Low molecular weight heparins have virtually replaced unfractionated intravenous heparin (UFH) for treatment of thromboembolic disease because of their more predictable pharmacokinetics. However, low molecular weight heparins have a long duration of action, reversal of their effect is difficult and their dosing is difficult to predict in patients with renal impairment. As a result, UFH continues to be prescribed.

Numerous papers suggest that using weight-based nomograms for UFH prescribing resulted in earlier achievement of a therapeutic activated partial thromboplastin time and more reliable anticoagulation (Raschke et al, 1993). Thus national and international guidelines from varying specialties unanimously recommend the weight-based approach (Campbell et al, 2003).

The authors noticed a great deal of variation in UFH prescribing protocols in NHS hospitals that they have worked in. As a result, a questionnaire survey of all NHS hospitals in England was performed to investigate what proportion used weight-based UFH protocols. Replies were received from 91 (60%) of hospitals. Only 32% of trusts had a protocol for UFH that used a weight-based nomogram.

A consultant haematologist from each hospital that did not use a weight-based protocol was then surveyed to try to investigate why this was the case. Of the 27 (54%) consultants who replied, 52% did not believe that weight-based nomograms were beneficial and 22% were unsure.

The authors believe that NHS hospitals that do not use weight-based UFH prescribing protocols should reconsider their guidelines given the evidence for this approach.

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