Attitudes, Informed Consent Obtaining Rates and Feelings About Physical Restraint Use Among Nurses

Hemşirelerin Fiziksel Kısıtlama Hakkındaki Duyguları, Bilgilendirilmiş Onam Alma Oranları ve Tutumları

Ayten DEMİR ZENCİRCİ, MD[a]

[a]Nursing Department,
Ankara University
Health Sciences Faculty, Ankara

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Yazışma Adresi/*Correspondence:*
Ayten DEMİR ZENCİRCİ, MD
Ankara University
Health Sciences Faculty,
Nursing Department, Ankara,
TÜRKİYE/TURKEY
aytendemir2000@yahoo.com

ABSTRACT Objective: The study determined 1) informed consent obtaining rates 2) reasons not obtaining informed consent, 3) feelings against physical restraint, 4) perceptions about patient rights among nurses and 5) patient and surrogate reactions against nurses who did not ask for informed consent. **Material and Methods:** This prospective study used descriptive, analytical and cross-sectional methods with 254 nurses working in intensive care units, neurosurgery wards, and emergency departments of four hospitals. The questionnaire consisted of open-ended questions and was applied by face-to-face interviews. **Results:** Most nurses (97.6%, n= 248) used physical restraint without informed consent. The reasons, emotions, and complaint were as follows: "if we ask for permission they get angry and behave aggressively to us" (85.1%), "patients have already harmed themselves" (83.1%), "do not understand even if I explain" (83.1%) and "no reason to ask since they will not give consent" (80.6%). Patients under physical restraint stated their complaints about nurses to administrators (48.4%), "begged for not being tied/untied" (71.7%), "developed introversion" (43.3%), and developed "feeding and hydration problems" (7.9%). Surrogates "Asked reason for physical restraint at each visit and declined to accept it" (57.1%), "Left clinic crying when patient was physically restrained" (55.1%), and "Tried to find somebody they know in the hospital to get help to end physical restraint" (46.5%). Nurses stated that after physical restraint they were either relaxed or felt sorry. **Conclusion:** Obtaining informed consent protects patient rights before using physical restraint. Nurses, therefore, should be more pro-active for informed consent.

Key Words: Informed consent; restraint, physical; patient rights; nursing

ÖZET Amaç: Bu çalışma, hemşirelerin 1) bilgilendirilmiş onam alma oranlarını, 2) bilgilendirilmiş onam almama nedenlerini, 3) fiziksel kısıtlama uygularken neler hissettiklerini, 4) hasta haklarını algılamalarını ve 5) hasta ve hasta vasilerinin hemşirelere karşı tepkilerini tanımlamak amacıyla yapılmıştır. **Gereç ve Yöntemler:** Bu çalışma dört hastanenin yoğun bakım üniteleri, beyin cerrahi servisleri ve acil bölümlerinde çalışan 254 hemşire ile tanımlayıcı, analitik ve kesitsel nitelikte yapılmıştır. Soru formu açık uçlu sorulardan oluşmaktadır ve yüz yüze görüşme tekniği ile uygulanmıştır. **Bulgular:** Hemşirelerin çoğunluğu (%97.6, n= 248) bilgilendirilmiş onam almaksızın fiziksel kısıtlama uygulamaktadır. Hemşirelerin bilgilendirilmiş onam almadan fiziksel kısıtlama uygulama nedenleri, fiziksel kısıtlama uygularken karşı karşıya oldukları duyguları ve yakınmaları aşağıdaki gibidir: "İzin almaya kalktığımızda bize öfkeleniyor ve saldırganlaşıyorlar (%85.1)", "Önceden kendisine zarar verici bir eylem yapmış oluyorlar (%83.1)", "Açıklama yapsam da anlamıyorlar (%83.1)" ve "İzin vermeyecekleri için onam almaya kalkmanın anlamı yok (%80.6)". Fiziksel kısıtlama uygulanan hastaların %48.4'ünün hemşireleri yöneticilerine şikâyet ettiği, %71.7'sinin "beni bağlama ya da çöz" diye yalvardığı, %43.3'ünün içine kapandığı ve %7.9'unda beslenme ve hidrasyon problemleri geliştiği belirtilmektedir. Hasta vasileri "Her ziyarette fiziksel kısıtlama nedenini sordu, ama kabullenemedi (%57.1)", "Hastasına fiziksel kısıtlama uygulandığını görünce klinikten ağlayarak ayrıldı (%55.1)" ve "Hastanede çalışan tanıdıklarına ulaşıp fiziksel kısıtlamayı sonlandırmaya çabaladı (%46.5)". Hemşireler fiziksel kısıtlama sonrasında ya rahatladıklarını ya da üzüldüklerini belirtmişlerdir. **Sonuç:** Fiziksel kısıtlama uygulamadan önce bilgilendirilmiş onam almak hasta haklarını korumaktadır. Bu nedenle hemşireler bilgilendirilmiş onam alma konusunda daha aktif olmalıdır.

Anahtar Kelimeler: Bilgilendirilmiş onam; fiziksel kısıtlama; hasta hakları; hemşirelik

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All healthcare activities and medical treatments require consent from patients or surrogates, because fundamental moral duty forbids any actions against a person's wishes and dignity. Informed consent thus entails a shared decision by both patient and health professional.[1] In a patient, whether or not s/he has a doubtful capacity, health care professionals are obliged to take necessary steps against deterioration first and then consider capacity and consent matters.[2]

Informed consent is widely recognized in national and international guidelines as well as in legislation.[3-6] Four basic elements of informed consent developed starting with Nuremberg trials, which are also valid for patient care, are the following:[1]

a) "Capacity to consent;

b) Full disclosure of relevant information;

c) Adequate comprehension of the information by the participant;

d) Voluntary decision to participate and withdraw from participation at any stage without prejudice of the participant. Participant withdrawal should be accepted and withdrawing participants should not be expected to give any reasons for their decision."

One could perceive informed consent well only if she has a good understanding of human rights and ethics. Human rights are defined by the American Nurses Association (ANA) as "assertions that call for treating human beings as ends in them, rather than as goals or purposes of others".[4] Ethical principles, of which three guides all care activity used by nurses are the following: respect for persons, beneficence, and justice. These principles were outlined at the US federal level in the Belmont Report in 1979 [The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (NCPHS)].[7] The dignity and rights of the patient come before the goals of any research or anything since many medical or nursing cares, though they are acceptable, could be harmful or outweigh the expected benefits.[2]

The recent literature on informed and shared decision within clinical care has revealed a pronounced tension among three competing factors:

- Paternalistic conservatism about information disclosure to patients has been eroded by moral arguments and largely accepted by the medical profession,
- While many patients may wish to be given information about available treatment options, many also appear cognitively and emotionally too ill to understand and to retain it, and
- Even when patients do understand information about potential treatment options, they do not necessarily wish to make such choices themselves and might prefer to leave final decisions to the clinicians.

The second and third factors apparently conflict with the first and make the case more difficult.[8]

Physical restraint has become a common method for difficult clinical situations in hospitals although it has been well recognized in years that nurses should obtain consent from the patient before any nursing care procedure.[4,9] Similarly, informed consent has become a common way of protecting patients and healthcare providers as well from unexpected consequences of physical restraint use, because of increased concern for human and patient rights in the USA and the UK.[10] While physical restraint is needed or necessary in patients with insufficient mental or decision-making capacity or psychiatric patients, informed consent is still necessary and should be obtained at least from surrogates.[11-13] In other words, a patient has the right at any stage or under any circumstances to agree or to disagree with a certain treatment.[14,15]

Some codes of ethics and regulations are in use in various countries but there are few in Turkey. The only existing code is "Medicine and professional ethics", which was accepted in 1960 and was later revised in 1998.[16] The Patients' Rights Regulations put into effect by the Ministry of Health in August 1998 is the first and only regulation.[3] The content of these is similar to the Declaration on the Promotion of Patients' Rights in Europe.[15] More, however, has to be implemented in Turkey to avoid misguided/misused physical restraint without informed consent

and its consequences of legal challenges for maltreatment, negligence or human rights.

The aim of informed consent is to protect the autonomous choices of vulnerable persons such as physically restrained patients. Informed consent for medical interventions should be based on size and likelihood of the risks associated with the proposed intervention. As the risks associated with the use of physical restraints are significant, consent for their use is crucial.[17]

Despite missing or hidden confidential data on informed consent in physical restraint at intensive care units (ICUs), neurosurgery wards, and emergency departments, higher interest in patient rights and increased potential liability risks for nurses in hospitals led the author to carry out this prospective research to describe current clinical practice for informed consent in physical restraint.

AIM

The study determined 1) informed consent obtaining rates 2) reasons for not obtaining informed consent, 3) feelings against physical restraint and 4) perceptions about patient rights among nurses and 5) patient and surrogate reactions against nurses who did not ask for informed consent.

MATERIAL AND METHODS

DESIGN AND SETTINGS

This descriptive, cross-sectional, and analytical study was implemented at four university hospitals in a highly populated Turkish city, during July 20 and September 6, 2005. The universe of the study included 24 adult ICUs, neurosurgery wards, and emergency departments. Of these clinics, seven were in university hospital A, three in university hospital B, seven in university hospital C, and seven in university hospital D. Patients in these three types of units were physically restrained when agitated or capable of self-extubating or removing vital catheters, drains, and other invasive monitoring devices.

RESEARCH POPULATION AND RESPONSE RATES

The research population comprised all nurses who worked in above mentioned hospital units from July 20 to September 6, 2005, based on the following inclusion criteria: the nurses with (1) more than one year working experience, (2) experience in applying physical restraints on hospitalized adult patients within one month of the study, and (3) willing to share their experiences. Nurses who have worked for less than 1 year or who were on vacation or on medical leave during July 20 - September 6, 2005, were excluded. Shifts for nurses in the hospitals were 8 h : 08.00 - 16.00 h, 16.00 - 24.00 h, 24.00 - 08.00 h; or 12 h : 08.00 - 20.00 h, 20.00 - 08.00, or 16 h : 16.00 - 08.00. All nurses in hospitals A (n= 59) and B (n= 29) were included the population. Six nurses in hospital C (n= 95) and twelve nurses in hospital D (n= 89) refused to participate in the interview. Overall, 18 nurses did not participate and the total response rate was 93% (N= 254).

PILOT TRIAL

Pilot trial was with 30 nurses, who were not a part of the main research population. The pilot study consisted of open-ended face-to-face interviews, of which both questions and answers were recorded on tape. Then, based on the pilot interviews, forms and questions were revised. The interviews in the pilot trial provided a test of comprehensibility and clarity of questions.

DATA COLLECTION

The data collection instrument was a questionnaire with open-ended questions. Data were collected by face-to-face interviews. The questionnaire consisted of two sections. Section one included questions on age, marital status, number of children, education level and section two questions on the informed consent rate of nurses from patients/surrogates, the reasons for not obtaining informed consent, the reactions by patients/surrogates who did not give informed consent, and nurses' emotions, feelings, and views about patient rights.

Weekly nurse shift lists were obtained from administrators and interviews were scheduled with nurses prior to the interviews. Data were collected by face-to-face interviews with nurses and answers were recorded. The interviews took place between 07.00 AM and 19.00 PM from Monday to Friday,

during July-September, 2005. The mean duration of each interview was 20 ± 1.9 minutes. During the interviews, the researchers recorded the answers after asking the questions to the nurses in the list.

Data classified for statistical analysis were loaded into the Statistical Package for Social Sciences (SPSS for Windows 11.5).

ETHICAL CONSIDERATIONS

Although all hospitals had Ethical Committees, hospital administrations had decided that there was no need for any ethics investigation since there were no invasive practices planned for humans in the research. Instead, hospital administrators provided written approvals and individuals gave their verbal consents after they were informed about the content and the methodology of the research. In addition, all individuals were assured of anonymity without recording the names.

RESULTS

RESEARCH POPULATION

The research population consisted of 254 nurses who worked in ICUs (n= 172, 67.7%), emergency departments (n= 53, 20.9%), and neurosurgery wards (n= 29, 11.4%). Their age mean was 27 years (SD = 4.6). Ninety-one (35.8%) were married and 57 (22.4%) with children. They had graduated from Nursing School (n= 99, 39.0%), Vocational Health High School with baccalaureate degree (n= 80, 31.5%) or Health Services Vocational School with associate degree (n= 75, 29.5%). None of the nurses had attended in-service training on physical restraint.

INFORMED CONSENT AND PHYSICAL RESTRAINT

Two hundred forty-eight nurses (97.6%) used physical restraint without informed consent from patients but 54.4% (n= 135) of nurses reported that they explained to the patients the reason for physical restraint. Nurses explained the reason why they did not receive informed consent from the patient as follows: 85.1% 'if we ask for permission they get angry and behave aggressively to us'; 83.1% 'they already harmed themselves'; 83.1% 'even if we explain patients do not understand'; 80.6% 'no reason to ask since they do not give consent'; 78.2% 'If I don't apply physical restraint I might cause harm to the patient, therefore, there is no need to obtain informed consent' (Table 1). None of the nurses received informed consent from surrogates of patients with decision-making incapacity and only 52.8% (n= 134) of nurses explained

TABLE 1: The reasons for not taking informed consent from the patients (n= 248) and surrogates (n= 254) before applying physical restraint.

a) Patients	n	%
When asked they get angry and assault us	211	85.1
They already harmed themselves	206	83.1
They don't understand the necessity even if I explain	206	83.1
No reason to ask since they don't give consent anyhow	200	80.6
If I don't apply physical restraint I might cause harm to the patient	194	78.2
No procedure to ask for it, and I don't know whether I should ask for it	33	13.3
I don't think it is necessary, a nurse as a professional can decide on it	13	5.2
Accept nicely without any reaction	1	0.4
b) Surrogates	n	%
They don't give even if I ask for it	241	94.9
It is waste of time, we are too busy	174	68.5
They get angry and assault us	155	61.0
I don't know it, there is no procedure like that	79	31.1
I don't think it is necessary, a nurse as a professional may decide	29	11.4
Accept nicely without any reaction	7	2.8

the reason for physical restraint after surrogates observed physical restraint applied to the patients. Similarly, nurses gave the following reasons for not obtaining consent from surrogates: 94.9% 'they do not give consent even if I ask for it'; 68.5% 'it is a waste of time, we are too busy for that'; 61.0% 'when we ask they get angry and act aggressively to us'; 31.1% 'I did not know permission was required; there is no such procedure' (Table 1).

REACTIONS OF PATIENT AND SURROGATES

Patients under physical restraint complained about nurses to their relatives (59.4%), physicians (52.0%), administrators (48.4%) or assaulted nurses physically by swearing (86.2%), kicking (84.6%), spitting (71.3%), scratching (65.7%) or 'behaved stereotypically' (53.9%) or 'got too agitated to harm themselves' (81.1%), 'begged for not being tied / untied' (71.7%), 'developed introversion' (43.3%) or 'refused food and drug and stopped reacting to invasive interventions' (7.9%) (Table 2). While 22.8% of surrogates accepted physical restraint for their patients without any reaction, 57.1% 'kept asking the reason during every visit and did not accept it', 55.1% 'left clinics crying when they saw the patient tied', 46.5% 'tried to reach somebody in the hospital to ask help to end physical restraint', 40.6% 'orally or physically assaulted', and 'complained to physicians (34.6%) and administrators (31.9%)' (Table 2).

TABLE 2: The reactions of patients applied physical restraint and surrogates (n=254)

a) Patients	n	%
Complained to the relatives	151	59.4
Complained to the physician	132	52.0
Complained to administrators	123	48.4
Swore	219	86.2
Kicked	215	84.6
Spat	181	71.3
Scratched	167	65.7
Stereotypic reactions	137	53.9
So agitated that he could harm him/herself	206	81.1
Cried saying not to be tied and begged for untied	182	71.7
Developed introversion	110	43.3
Rejected to have oral liquids, food, and drug, stopped reacting to invasive interventions	20	7.9
Threatened as saying "I will show your day"	4	1.6
Sexually harassment both verbally and physically	4	1.6
Frightened by a hanger of IV fluid container and assaulted by fist/kick	3	1.2
Asked to be discharged "if tied"	3	1.2
Asked "Am I crazy why you tie me?"	2	0.8
b) Surrogates	n	%
Asking the reason for it at each visit and do not accept the case	145	57.1
Left clinics crying when seeing the patient tied	140	55.1
Reach to people they know in the hospital to stop the restraint	118	46.5
Verbal and physical assault	103	40.6
Complained to the physician	88	34.6
Complained to administrators	81	31.9
Accept nicely without any reaction	58	22.8
Untied the patient and left the hospital	12	4.7
Had serious quarrel	4	1.6
Wished bad things, saying "wish your mom/dad were here"	2	0.8
Bribed the janitor to untie their patients all the time	1	0.4

EMOTIONS AND PERCEPTIONS OF NURSES ABOUT PATIENT RIGHTS

Nurses had different feelings after their physical restraint use: 94.5% 'relaxed since she thought it was for the patient's health', 44.9% 'thought patients would not harm themselves and the environment anymore', 80.7% 'were sorry when patients begged not to be tied', and 68.5% 'were sorry since they thought patients had the right to get care without any ties', 51.6% 'got angry against the hospital since the number of nurses was inadequate and therefore they had to use physical restraint', 32.7% 'got angry with the patients since they induced them to tie them', and 32.3% 'got angry with the patients since they physically mistreated me'(Table 3). Only 75 (29.5%) nurses accepted physical restraint as a violation of patient rights. Thirty four (45.3%) out of these 75 nurses defined physical restraint as patient rights' violation because of its use due to 'nurse shortage', patients' right for health care without any physical restraint (48.0%, n = 36), and its use "without a consent from patients"(6.7%, n = 5).

DISCUSSION

INFORMED CONSENT AND PHYSICAL RESTRAINT

Almost all nurses in the study used physical restraint without an informed consent from any patient or surrogates although informed consent was essential and should target at protecting autonomous choices of vulnerable persons since risks associated with the use of physical restraints were significant.[17] The need for informed consent has become even more compelling when one considers that restraints had not been proven to be effective or beneficial methods and it is argued that restraints are still non-validated therapy, their investigational use, therefore, requires a higher standard of informed consent.[18-21] In addition, one should keep in mind that frequent use of restraints lead to arguments about the effectiveness and standard of any health care. Care staff, therefore, have to have a moral obligation to do no harm (non-maleficence), and to promote good (beneficence), which implies that health care professionals have to balance risks and benefits of the restraint well.[14] However, this is sometimes confounded with patients without any capacity to consent and rapid decisions are needed to keep patients safe.[22]

Based on the elements of informed consent, care provider should provide information to patients or surrogates about the nature of proposed treatment with its risks, benefits and alternatives to restraint.[14] Involving patient who is capable or surrogate in decision making could allow all parties to solve the case before conflict.[14] However, the unpredictable nature of critically ill patients may preclude early conversations about restraint use and does not guarantee the prevention of adverse effects of physical restraint even with informed consent.[23]

In these situations, discussions with the surrogate or patient occur after initial application.[17] Restraints may be needed in some patients with decisional capacity. However, questions of patient

TABLE 3: Nurses' emotions after applying physical restraint (n= 254).

Nurses emotions	n	%
I relax since I think it was for patient's health	240	94.5
I relax since patient would not harm him/herself and environment anymore	114	44.9
I feel sorry when patients beg not to be tied	205	80.7
I feel sorry since I think patients have the right to get care without any ties	174	68.5
I got angry with the hospital administration since the number of nurses is inadequate and therefore I had to use physical restraint	131	51.6
I got angry with the patients since they induced them to tie them	83	32.7
I got angry with the patients since they physically mistreated me	82	32.3
I am too busy and too tired to feel anything	4	1.6
I did something not good for a human and was 'very sorry'	2	0.8

capacity are not suitable grounds overriding the patient's fundamental rights. Nurses, therefore, have a moral responsibility to uphold and respect the patient's dignity and autonomy regardless of patient's ability for reasoning and comprehension of the information. If the ability of the patient to understand the risks and proposed benefits from physical restraint is seriously compromised, then, the surrogate decision maker should convey the patient's wishes and represent the patient's best interest.[17]

The cases in nursing homes were somewhat similar to clinics: 87.7% required that residents were informed before physically restrained; 72.3% required that residents were informed of associated risks and 49.1% required that residents gave their consent. Consent was sought from the resident's family or legal guardian in 87.7% of nursing homes, when a resident was unwilling or unable to give their consent.[24]

The nurses in our study assumed that they had the right to use physical restraint without any informed consent, which is very disturbing. Since the medical profession was accused of paternalism and jeopardizing patient in the past, preserving patient autonomy gained importance in the western world.[25,26] However, the problems in countries that have not absorbed patient rights, continue. The reasons for nurses considering that they have full right to decide on behalf of patients and to connect these to professional autonomy might be as follows: insufficient education, lack of standards for informed consent in Turkey and misinterpretation of the standards. The concept by the ANA states that nurses are expected to "take appropriate action for their clients, regarding any instances of incompetent, unethical or illegal practice(s) by any member of health care team or the health care system itself, or any prejudicial action".[4] Under these conditions, nurses should grow up to "mind of wisdom". No doubt, those patient rights for informed consent choices are now widely accepted for any good health professional.[8]

If patients feel that nurses or doctors have misused their right for informed consent about care, they could take the case to the court. Therefore, clinicians have to clarify what they propose to do and why they want to do it.[8]

REACTIONS OF PATIENT AND SURROGATES

When the reactions of patients and surrogates are considered, physical restraint use should be decreased. Strong reactions against physical restraint might be caused by not taking informed consent. It was clear that surrogates did not comprehend the physical restraint use and just panicked.[19] Physical restraint might be perceived as inhumane by both patients and surrogates. The reactions of patients were as follows: refusal of eating or taking drugs, developing introversion, and in three cases, leaving the hospital. In one of these cases, the surrogate was a judge. In this context, one might consider that either patients or surrogates were not aware of their rights or patient rights were not active in practice, or patients or surrogates may think that they may not be given care if they reject the care provided. A study by Zülfikar and Ulusoy showed furthermore that 32% of inpatients in medical and surgical wards did not know their rights, 38% their diagnosis, even 63% their operation.[27] Patients under physical restraint have developed agitation, confusion, anger, depression, insomnia, shyness, lowered self-respect at higher levels and paranoid ideas such as "I didn't feel like I was a human being. I felt I was just a number.[28-32] I thought they were going to kill me".[33]

EMOTIONS AND PERCEPTIONS OF NURSES ABOUT PATIENT RIGHTS

Nurses, during interviews, hesitated to reply to questions, expressed patience, sorrow, and anger simultaneously. The study showed a grim picture for both patients, who begged not to be physically restrained and nurses who used the physical restraint. Here, one could feel the emotions of patients or surrogates and the nurses' sorrow. This also reflects the ethical conflict and dilemma faced by nurses. This was because nurses could harm patients physiologically or psychologically while they were trying to provide care to the patients. During interviews, it was clear that, the nurses experienced dilemma.

Our results are consistent with those of previous studies. Nurses in some studies defined physical restraint as a boring, disturbing, fearful, frustrating, and a terrible experience, but still a last resort.[33-37] They also felt bad, hated the inhumane physical restraint, and found it "cruel" but still applicable for the sake and safety of the patients.[38] Nurses also felt sorry for physical restraint they applied, one stated that they might use physical restraint as 'a legal way of hurting patients'.[39]

The number of nurses in the hospitals was low. There were some hospitals with only one or two intensive care nurses in night shifts. Higher workload of nurses might be one of the reasons that made them feel anger against the hospitals and probably the patients, because of their decision, causing difficulty in the care process.[37] Nurses in this study felt patients had the right for proper healthcare without physical restraint and considered physical restraint a human rights violation if it were without an informed consent.

A critical care staff has to provide a good and beneficent care without harm and maleficence.[14] Health care professionals under these circumstances have to weigh benefits likely against risks and act in accordance with the principle of "A medical attempt must require first informed consent form patient or surrogate" of The European Patient Rights Declaration.[3] Physical restraint may not be considered a patient rights violation only after a good judgment on patient's condition, trying alternative methods, and deciding in accordance with the principles mentioned. As stated by the nurses in the study, physical restraint is still a human rights violation when applied because of nurse shortage or without an informed consent. As one can understand, the answers to the questions about the use of physical restraint are the difficult ones, such as "Is physical restraint not a restriction of patient freedom even if it is used to save the patients from any harm? It is clear, in this context, that physical restraint is violation of rights but is sometimes needed. Even then, facing ethical dilemmas is unavoidable.

CONCLUSION

Professional nursing practice accepts that the use of physical restraints is occasionally unnecessary, harmful, and potentially deadly. Only this evidence alone shows that use of physical restraints is an anathema to best practice principles, a denial of patient autonomy, and beneficent professional health care practice principles. Physical restraint used by nurses sometimes violates patients' autonomy or self-respect and causes patients to lose their trust to the nurses. One should agree that physical restraint is an unethical assault on patients' rights and should be used carefully after alternative methods are tried.[40]

Under these conditions, authors recommend that nurses, including those who used physical restraint most without any informed consent in this study, try various strategies like negotiation or explanation first and restraint later only in certain cases. Getting patients involved in the process of decision is another good and humane approach. All these approaches together could help all parties benefit.

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