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The Lived Realities of Chemical Restraint: Prioritizing Patient Experience

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In *The Conditions for Ethical Chemical Restraint*, Crutchfield and Redinger (2024) propose ethical standards for the use of chemical restraints, which they consider normatively distinct from physical restraints. While we accept their general thesis, we find their analysis does not adequately frame the ethical significance of chemical restraints, which concerns the potential for treatment teams to prevent or cause significant harm to vulnerable patients, specifically through the capacity of chemical restraints to alter patient psychological states. In our response, we draw from the lived experiences of patients to demonstrate how ethical guidelines must consider key clinical, psychosocial, and social structural elements which shape this ethical problem (Dougherty and Fins 2023). In doing so, we hope to show how bioethicists can better contribute to the development of comprehensive guidelines that prioritize the well-being and dignity of individuals who are at risk of or are actively being chemically restrained.

Crutchfield and Redinger argue that, as with all major medical interventions, both physical and chemical restraints require the patient's informed consent. Given that restraints are commonly used in instances where patients lack decisional capacity, focusing on a first-person informed consent process is not only ethically inappropriate, but may further obscure a treatment team's obligation to protect incapable patients from imminent harm, particularly in time-sensitive situations. The second point derived from this clinical reality is that any use of restraints necessarily involves populations who are also vulnerable to the inappropriate application of restraints and medical abuse. This vulnerability stems in part from being decisionally impaired and therefore unable to communicate authentic preferences. We argue then that the primary

focus in any analysis of the ethical use of restraints must necessarily center how to balance respecting patient self-determination while mitigating risks of serious patient harm.

The psychological effects produced by chemical restraints pose unique considerations in navigating this ethical dilemma. While Crutchfield and Redinger only consider two factors as relevant in differentiating chemical restraints from physical ones – namely, their impact on patient alertness and potential to restore decisional capacity – service users and ex-patients report a myriad of psychological states produced by psychotropic drugs. Thus, in applying them, treatment teams are prompted to engage in a process of interpreting drug effects; which implicates broader social, economic, and political constructions of psychotropic drugs that extend beyond the clinical encounter (Cohen et al. 2001). We highlight two reasons as to why this process of drug effect interpretation has ethical implications for informed consent and treatment over objection. First, consider that chemical restraints could momentarily shape a patient's own preferences in ways that do *not* reflect their extant value system when *not* under the effects of chemical restraints. In such instances, treatment teams may mistake a patient's behavioral agreeableness for an authentic informed consent, or as a window of opportunity to proceed with treatment that the patient would not otherwise accept.

Second, psychotropic drug use shapes psychosocial elements in the clinical space through altering the interpersonal relationships between patients, multidisciplinary teams, and healthcare institutions. Even if patients are more “decisionally capacitated” as a result of chemical restraints, they nevertheless report feeling as though treatment teams have attempted to alter

their mental experiences and even their very personhood through forced medications (Butterworth, Wood, and Rowe 2002). Some patients who have experienced coercion with psychotropic drugs have reported becoming behaviorally compliant due to their feelings of having been dehumanized, and subsequently rendered powerless, in the provider-patient relationship (Dougherty 2021). Soros (2019, 120) describes her acquiescence to medication while in a psychiatric facility as submission instead of consent:

I call this institutionalized rape, the statement began, and then I detailed how I would be submitting to the injection only because otherwise I would be restrained by force. My submission should in no way be construed as consent. You are doing this against my will.

Together, chemical restraints present unique ethical challenges because clinicians may mistake a patient's reported decisions as an expression of their authentic wishes, as opposed to a drug-mediated preference or strategic behavioral compliance by patients. Additionally, the harm incurred may have long-term consequences for patients, beyond the immediate clinical encounter, which we argue run counter to the aim of fostering patient self-determination. In summary, Crutchfield and Redinger's framing of psychotropic medications risks clinicians inappropriately prioritizing clinician intent as the source of the ethical appropriateness of their administration rather than consideration of the clinical reality of psychotropic drugs, as informed by clinical, psychosocial, and social structural factors.

Patients, ex-patients, and service users of mental health services have long highlighted how chemical restraint use stems from broader systemic issues (Britz and Jones 2023). Systemic oppression, including ableism and sanism, underlies pervasive and well-documented cultural biases concerning the decisional capacity and dangerousness of populations with psychiatric or intellectual disabilities. Ignoring or invalidating the testimony of service users about their own experience of forced medications can be understood as a form of harming them in their capacity as knowers and amounts to an epistemic injustice (see Smolenski 2021). Similarly, the mind-altering properties of psychotropic drugs risk diminishing a patient's ability to both *experience* discontent and *express* protest in healthcare settings; both of which may actually help patients protect their own self-interests and guard against medical abuse. In addition to reporting trauma from being chemically restrained, service users have also reported that their experiences of being

restrained were in situations that could have been prevented through proper staff training and management (Rose et al. 2017). Indeed, ongoing economic transformations in society have shaped the introduction and ongoing utilization of psychotropics in healthcare settings. In the context of shrinking psychosocial services, the rise of chemical restraints can be motivated by healthcare systems seeking cost-effective means to manage "difficult behaviors" among vulnerable patient populations (Dougherty 2019).

The incorporation of patient perspective sheds light on the unique typologies of injustice at every level in the healthcare enterprise: from individual patient encounters involving chemical restraint, to hospital systems that may use chemical restraint as a cost-saving measure, to social biases that stigmatize those who have been or will be involuntarily treated. Still, we do not suggest that our considerations establish a case to withhold chemical restraints in general. Rather, based on the foregoing analysis, we offer several recommendations for considering the ethical permissibility of their use. First, analysis should begin with an adjudication of the patient's capacity, with an understanding that if a patient is incapable, their informed consent cannot be properly sought. Second, chemical restraints should be considered a "last resort" intervention when available psychosocial resources to deescalate distressing or violent behavior are demonstrated to no longer be beneficial or risk harm to treating staff. If there is no alternative but chemical restraint, clinicians should be offered guidance as to whether a patient's reported decisions following restraint reflect chemically-restored decisional capacity or, instead, socially-desirable states of behavioral compliance. Finally, multidisciplinary teams should understand specific methods of rebuilding rapport once chemical restraints are used, to the fullest extent that doing so is possible and appropriate. Any use of such restraint ought to include restorative efforts to rectify this broader.

We conclude by underscoring the more general responsibility of bioethicists to analyze the ethical significance of chemical restraints. While our work here cannot encompass the full spectrum of patient narratives, we aim for this commentary to highlight the value of such insights. Doing so serves many purposes: to illuminate the ethical implications of chemical restraints, rectify the ongoing epistemic injustices toward patient expertise, and aid in analyzing the clinical, psychosocial, and social structural elements which shape their use. In considering the complex interplay of these elements, bioethicists can continue to derive guidelines for clinical decision-making, as we have

attempted here. But, more broadly, we believe that doing so allows the field of bioethics to better envision and work toward a healthcare system that has eliminated inappropriate treatment and medical abuse altogether.

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