ABSTRACT

Dentists providing treatment to individuals with developmental disabilities are often faced with unique medical/legal issues. Obtaining informed consent when a patient does not have capacity can be an involved process. Issues regarding therapeutic aides used for immobilization (i.e., restraint) during treatment may further complicate the situation. This area is controversial and has even resulted in legal difficulties for some dentists. Several topics related to the use of restraint are addressed in this article. A review of the literature and applicable laws pertaining to consent issues for people with special needs is presented and appropriate use of medical immobilization is discussed. Existing guidelines are reviewed. Informed consent and the use of restraint should be incorporated into overall guidelines for the use of anesthesia, sedation, and alternative behavior management techniques in providing dental care to patients with special needs.

KEY WORDS: consent, restraint, autonomy, constitutional law

Consent, restraint, and people with special needs: a review

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Informed consent

The concept of informed consent is grounded in the principle of patient autonomy. The American Dental Association’s Principles, Code of Professional Conduct, and Advisory Opinions state, “The dentist has a duty to respect the patient’s rights to self-determination and confidentiality.” It goes on to explain that, “…professionals have a duty to treat the patient according to the patient’s desires, within the bounds of accepted treatment … the dentist’s primary obligations include involving the patient in treatment decisions in a meaningful way, with due consideration being given to the patient’s needs, desires and abilities …. “1 When a person does not have the capacity to consent however, issues of autonomy become more complicated.

Informed consent is not simply a piece of paper signed by a patient or a guardian. It is the process of communication between a doctor and a patient in which a patient grants permission for the proposed treatment based on a realistic understanding of the nature of the illness, description of procedure, risks and benefits, and treatment alternatives, including no treatment at all.2-4 The discussion should include all alternatives regardless of cost or the extent to which the procedures are covered by insurance.2

This communication is both an ethical obligation and a legal requirement spelled out in statutes and case law in all 50 states.2 There are two types of consent. Explicit consent is the patient’s stated decision to undergo treatment. Implied consent is the appearance that the patient has voluntarily submitted him/herself for treatment. It arises from the signs, actions, or conduct of an individual (i.e., the patient makes an appointment, presents for treatment, and willingly provides a medical history and insurance information).

While most institutions obtain general consent for routine dental care, it is advisable to obtain a “specific” consent for behavior management techniques, especially for restraint. Specific consent is usually sought for removal of body parts, other surgical procedures, and anesthesia. Emergency situations that would otherwise lead to serious disability or death do not require informed consent, although an effort to obtain consent should be made as long as it does not unnecessarily delay the treatment of the patient. Other exceptions to the necessity for informed consent vary by state. Practitioners should be knowledgeable about applicable state statutes. These include “simple and common” exclusions (i.e., the risk is so remote or commonly known as to not warrant disclosure, as in blood drawing), as well as exceptions to the duty to disclose. In addition, some states require written consent for certain procedures or diagnoses.6

For patients who lack capacity, the duty of granting informed consent belongs to the guardian. In the case of a minor child this is obviously the parent or legal guardian.7
Spec Care Dentist 29(1) 2009  59

CONSENT, RESTRAINT, AND PEOPLE WITH SPECIAL NEEDS

For patients with developmental disabilities who are over 18, the parent may not be considered the patient’s legal guardian and may have to have the patient adjudicated incompetent and then seek legal guardianship. Some state statutes provide for an advocate/representative to be able to consent for the patient or for an involved adult family member to do so. In the case of patients who have temporary loss of capacity, or who once had capacity, but no longer do, obtaining consent may be even more complicated. Advanced directives such as living wills, durable powers of attorney, and health care proxies should be encouraged for all competent patients, so that should they become incapacitated, their wishes may be carried out. In most states, adult patients who have never been adjudicated incompetent have the right to make decisions about their own treatment, including the right to refuse treatment. This applies not only to geriatric patients with fluctuating or questionable capacity, but also to psychiatric patients who have not been adjudicated incompetent (exceptions for treatment in life threatening situations do apply). In cases where mental capacity and legal competency are in question, professional legal counsel should be sought. The risk management departments of most hospitals and institutions are well versed in such issues.

Ideally, informed consent should be obtained by the dentist and witnessed by a staff member. The witness is attesting to the fact that the informed consent process took place. In the case of a person residing in a group home, it may not be feasible or even possible for the practitioner to meet face to face with the patient’s guardian. Most group homes are familiar with the process of getting consent and can be very helpful. The residence manager or nurse may provide the practitioner with the relevant information about the guardian. Consent forms may be sent with the patient’s escort along with an explanation of the proposed treatment. It is useful to have the practitioner’s contact information easily accessible on the consent form, so that the guardian may contact the dentist with any questions. For specific consents for restraint, surgery, anesthesia, etc., it is useful for the dentist to initiate contact with the guardian, either in person, or if necessary, by telephone, to be sure the process of informed consent is properly accomplished.

Failure to obtain informed consent may result in a criminal charge of battery (an unwanted touching), or in a claim of negligence (malpractice) for failure to fully “inform” the patient about a treatment or procedure.

Restraint
Prior to imposing restraints on any patient, informed consent must be obtained, either from the patient or his/her guardian. As previously discussed, legally competent adult patients have the right to make decisions about their own treatment, including the right to refuse treatment and restraints. The issues of patients’ constitutional rights and the concept of patient autonomy is therefore central to any discussion involving the issue of restraint. The balance of autonomy, patient safety, and quality of life is a recurring theme in the literature on restraint.

Governmental and regulatory perspective
The United States Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) glossary defines restraints as: “Physical restraints are any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the resident’s body that the individual cannot remove easily which restricts movement or normal access to one’s body. Chemical restraints are any drug used for discipline or convenience and not required to treat medical symptoms.”12 This definition is clearly aimed at defining restraint in a residential or acute care facility for behavioral (nontherapeutic) purposes. The Joint Commission (formerly JCAHO) differentiates between restraint of medical/surgical patients and the restraint/seclusion of behavioral health patients. “The specific device used to restrain a patient does not in itself determine whether these standards apply. Rather, it is the device’s intended use (such as physical restriction), its involuntary application, and/or the identified patient need that determines whether use of the device triggers the application of these standards. Therefore, these standards do not apply to the following: • Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes (for example, surgical positioning, intravenous arm boards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients). (emphasis added)”13

U.S. federal legislation (Children’s Health Act of 2000) discusses restraint in the Interpretive Guidelines for Intermediate Care Facilities (ICFs) for Persons with Mental Retardation. The law defines restraint as “a health-related protection, prescribed only by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists” (Tag w297).14 It also states that physical restraints for medical reasons should only be employed when no other option is available or when other options have proven ineffective.

Other regulations in the Guidelines require that facilities establish a “specially constituted committee” (aka human rights committee) consisting of “facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility” (Tag w261). The committee must review and monitor individual programs to manage inappropriate behavior and that involve risks to clients’ rights and protection (Tag w262). It further provides that these programs only be carried out with written consent (Tag w263) and that the committee monitor and review practices and programs as related to drug usage and physical

Romer
restraint among other client right issues (Tag w264). The establishment of such committees is clearly to protect patients’ rights and prevent abuse. However, in reviewing them, it is not clear that they directly pertain to restraint in a dental setting. In practice, many human rights committees will not allow a resident to be restrained even with the guardian’s informed consent, unless the committee also approves. This additional administrative hurdle may frustrate practitioners and might even discourage them from providing treatment for this population.

The Guide line’s standard on dental services is specific and extensive; regulating not only an annual exam and diagnosis, but also “comprehensive dental treatment” (Tag w354) including “dental care for the relief of pain and infection, restoration of teeth and maintenance of oral health” (Tag w356). The guidelines specifically note that exams should indicate that (dental) services were furnished, rather than that the individual was “unable to be examined” or “as best as can be determined” (§483.460(g)(2)).

Tag w349 allows for dentists to participate in the formulation of the individual program plan for each patient. It is here that the practitioner can express the need for sedation or restraint and therefore gains the approval of both the committee and the guardian. This may then avoid the time-consuming task of seeking consent and committee approval for each individual dental visit that will require restraint. This strategy would satisfy the regulatory requirements while not hindering the dentist’s ability to provide care via the necessary methods.

Federal law mandates that patients in long-term care facilities be provided with oral health care. The Surgeon General’s Report in discussing disparities in oral health status in Americans, specifically acknowledges that individuals “who have disabilities are at greater risk for oral diseases, and in turn, oral diseases further jeopardize their health.” In addition, the report notes that, “Nursing homes and other long-term care institutions have limited capacity to deliver needed oral care to their residents, most of whom are at increased risk for oral diseases.” The follow-up report, A National Call to Action to Promote Oral Health encourages public and private organizations to work to reduce oral health disparities in vulnerable populations including those with special needs.

New York State Department of Health definition of restraint specifically excludes “those devices customarily used in conjunction with medical, diagnostic, surgical procedures/treatments or movement/transfer of patients that are a regular or usual part of such treatment or procedure, e.g., body restraint during surgery.” The accompanying memo further states that: “The Papoose board is used in conjunction with procedures/treatment, e.g., routine dental examination, and is customarily a part of treatment. It does not meet the definition of a restraint.” Similarly, the New York State Office of Mental Retardation and Developmental Disabilities regulations (part 633.16e) allow for a mechanical device that would be used to perform a specific dental procedure on an uncooperative nondevelopmentally delayed patient may be used for a person with a developmental disability.

In what would appear to be contradictory to their own regulations, recently the New York State Department of Health cited a state dental facility for their restraint practices. The dentist was advised that for each patient that was restrained an “incident form” needed to be filled out. Upon review with the Office of Mental Retardation and Developmental Disabilities, this needless requirement is being removed, but it will take some time to change the associated regulation.

Much like the situation surrounding human rights committees, it seems that regulations that are meant to apply to behavioral restraints in group residencies are being applied to medical immobilization for necessary medical procedures. Colorado’s State Board of Dental Examiners has set forth specific policies regarding restraint. It includes sections on training, indications, contraindications, and medical documentation.

**Case law**

Connick reported on a North Carolina case in which a dentist had his license temporarily suspended for utilizing a restraint. She also reviewed a case that addresses the safe use of restraint to complete a dental procedure versus the patient’s liberty interests. The court in that case ruled that, “restriction of the freedom of the mentally ill when necessary to prevent danger to themselves and to others is a recognized and constitutional function of the state.”

The judiciary has addressed restraint in the MRDD population in several seminal cases. Wyatt v. Stickney established that restraints require a doctor’s orders that include the rationale for restraint. In *New York State Association for Retarded Children v. Rockefeller* (the Willowbrook case) the “protection from harm” theory was applied in forcing the establishment of standards in institutionalized settings. In *Youngberg v. Romeo*, another landmark ruling involving a state institution, the U.S. Supreme Court established that committed individuals have constitutionally protected liberty interests under the Due Process Clause of the Fourteenth Amendment. The court noted that such liberty interests “are not absolute; indeed to some extent they are in conflict.” The court recognized that it is sometimes necessary in an institutional setting to restrain an individual for safety reasons. To address this conflict the court adopted the professional judgment standard, “that courts make certain that professional judgment was in fact exercised.” This grants deference to the professional’s opinion over those formulated by judges and juries. Furthermore, “the decision, if made by a professional, is presumptively valid; liability may be imposed only when the decision by the professional is such a substantial departure from the accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”

In *Society for Goodwill to Retarded Children v. Cuomo*, the court found that “lack of sufficient dental care caused (a patient’s) gums to deteriorate
necessitating the surgical removal of nine of her teeth” and that her constitutional right to adequate care had been violated.31 In a case in Nebraska, the U.S. District Court overturned a previous verdict against a physician for restraining a mentally ill pre-trial detainee. The plaintiff had signed a consent form that included physical restraint upon entering the hospital as a detainee. The court concluded that, “The record as a whole does not support the declaration that the appropriate medical standard is limited to retaining persons in restraints only for that period of time necessary to keep that person from hurting himself or others while or immediately after he is in restraints. The record, rather, indicates a therapeutic feature.” Furthermore, “A professional decision maker made the decision about how long the restraints should remain on (the patient) and the decision, therefore, is presumptively valid.”12

Rationale for use of restraint
Several authors have discussed the rationale for restraint for dental procedures. Connick et al. point out that “the primary reason for the use of restraint is to guarantee patient and staff safety; the secondary reason is to deliver effective oral health care.”9 Casamassimo explains that dental restraint is used for “positive rather than negative ends; to facilitate rather than punish” and that, “restraint is support.”46 This concept is formalized in the American Academy of Pediatric Dentistry’s Guideline on Behavior Guidance for the Pediatric Dental Patient, with the updated term of protective stabilization used in place of “restraint.”44 The Academy’s foundation funded two recent studies on behavior management techniques. The first was a survey of members of the Academy which found that 73% of respondents utilize active restraint (i.e., by another person) for nonsedated children and 68% use passive restraint (i.e., using a medical device).47 A second study surveyed post-doctoral pediatric residency programs and reported that over 91% of programs teach protective stabilization (both active and passive) as an acceptable behavior management technique.48 Evans and Strumpf, who have published extensively on the need to decrease the use of restraints in long-term care facilities state that, “in making a decision about restraints the goal of care must be thoroughly weighed. The desired outcome for patients in acute care is generally cure or improvement of health through the use of sophisticated medical diagnostic and testing measures.”49 They further noted that elder patients who exhibit cognitive or behavioral impairments are more likely to be restrained. Also, physical restraint may be used to facilitate treatment in the cognitively impaired elder patient who is at greater risk for accidents and “less able to understand and cooperate with medical regimen and may behave in ways that endanger or disturb other patients or staff.”10

Shuman and Babeau propose that the decision to employ restraints for treatment is based on the assumption that in certain circumstances behavior needs to be controlled for the greater benefit of the patient. They also discuss the concept of passive neglect: the institution’s failure to fulfill a care giving obligation versus active neglect: the intentional failure to do so.12

In another paper, Connick et al. reported that 66% of patients in a developmental center required restraints for dental treatment due to resistant behavior. The authors point out that patients with severe and profound mental retardation who exhibit behavioral resistance may suffer dental neglect if they are not restrained for their needed dental treatment.50 In another article, Connick discusses some positive characteristics: they effect immediate behavior control, are easy to apply and are readily available.9

Helgeson elaborates on the poor outcomes associated with dental neglect in a long-term care setting such as pain, infection, bacteremia, inability to chew and speak, poor nutritional status, and low self-esteem. He states that preventive programs and daily oral hygiene care are key factors in controlling dental disease in the MR/DD and geriatric population.49

Peretz and Gluck found that informed parents were more likely to approve the use of restraints, emphasizing the importance of explaining the procedure to parents or guardians.39

Literature review
Physical restraint has been used in institutional settings in the United States for hundreds of years.9 Historically used in psychiatric settings, its use in pediatrics, geriatrics, and the developmentally disabled is well documented.9,33-42

The majority of the literature found in a recent search of Medline, Google Scholar, and the Cochrane Review focuses on restraints in mental health institutions and long-term care facilities. Interestingly, another large portion of the literature refers to restraint of suspects by law enforcement officials. There is certainly a gap in the literature concerning restraints and patients with developmental disabilities.

The restraints referenced in the geriatric and psychiatric literature are general behavioral restraints to prevent patients from harming themselves and others and not employed for stabilization during a specific medical or dental procedure. Dental restraints are temporary and specific and not analogous to general behavior restraints.31 Their purpose is to enable safe, efficient treatment and are only applied for the duration of a specific procedure.

The terms medical immobilization, protective stabilization, and physical intervention have been proposed as substitutes for the term restraint, in order to avoid the negative connotations of the word restraint.26,44,45 The use of these terms may also help to differentiate dental/medical restraint for treatment purposes from behavioral restraints in both the literature and the legislature.
CONSENT, RERAINT, AND PEOPLE WITH SPECIAL NEEDS

Patient's rights
O'Donnell poses the question of patients' rights versus the caregiver's obligation to ensure care. Should the dentist stand by and allow oral health to deteriorate because patients have a “right” not to brush their teeth? He discusses a “growing trend by well-intentioned but misguided bureaucrats to micro-manage the delivery of health care under the guise of defending the human rights of the disabled.” He voices concern that such administrative barriers may actually result in decreasing the number of providers who are willing to care for such patients.11

Klein points out that committed individuals have a constitutional right to adequate care.14 He argues that the constraint of an individual's liberty interest is minimal and temporary and recommends the use of restraints in the care of the disabled.

Fenton et al. actually cite the case law that pertains to an individual's liberty interest being protected by the Due Process Clause (of the Fourteenth Amendment) of the Constitution of the United States as well as the case law describing the constitutional rights of institutionalized patients to necessary medical care.30 They provide a thorough explanation of the “balancing test” used to resolve such constitutional problems and conclude that, "The use of restraint would appear to pass constitutional requirements under the Roe vs. Wade balancing approach."50

Ozar echoes this in his encouragement of dentists to practice beneficence, i.e., maximize the patient's well being.13 He advises that the technical standard of care for people with developmental disabilities be equivalent to the rest of the community. For people with disabilities this of course involves consideration of the individual's overall clinical circumstances. He further points out that dentists have an obligation to all patients, regardless of level of ability, to assist them in participating in treatment decisions.

Burtner contends that behavior management techniques such as sedation and restraint are not different from those employed with other patients, but rather more frequent in institutional settings.13

Psychological effects of restraint
In Peretz and Gluck's discussion on pediatric dental restraint, they point out that there is almost no literature describing the long-term psychological impact of restraint.39

A current review of the literature supports this finding.

Barton, Hatcher et al. reported no difference in anxiety levels of adult patients who were treated as a child with hand over mouth (HOM) and those treated with restraints.31

Interestingly, physical restraint was preferred by parents over sedation and HOM.30

Several authors have suggested that mechanical restraints may be less stressful than physical restraint by other people.32-33 Transfer of anxiety from staff to patients or perhaps the senses of being overpowered may be intimidating to patients. Beaver contends that mechanical restraint provides a sense of "comfort and security" to "[patients with developmental disabilities]."33

Author Temple Grandin, (who has both a PhD and autism), in her review of the literature on deep touch pressure to patients with autism, found that it had a relaxing, calming and comforting effect.54

In a paper on use of physical restraint for hospitalized patients, Mion et al. feel that, “Further studies are still required to ... determine if the beneficial effects of the physical restraints outweigh the deleterious effects on patient outcomes.”55

Wong reported on young medical patient's experiences being restrained and found that they had more negative than positive feelings about the experience. In addition the patients reported that their feelings were most influenced by the nurses' attitudes and caring (or lack thereof) behavior.56

Policies, position papers, guidelines, and published recommendations
American Academy of Pediatric Dentistry
The Academy's Guideline on Management of Dental Patients with Special Health Care Needs states that, “protective stabilization can be helpful in patients for whom traditional behavior guidance techniques are not adequate.” The Academy references its policy on Guideline on Behavior Guidance for the Pediatric Dental Patient which include protective stabilization by another person or mechanical restraint by a patient stabilizing device, or a combination of the two. They advise that the decision to use protective stabilization take into consideration: alternate behavior guidance modalities, the dental needs of the patient, the effect on the quality of care, the patient's emotional development and the patient's medical and physical considerations. The guidelines include recommendations on documentation and informed consent. In addition, they recommend that, when appropriate, the practitioner provide the patient with an explanation of the need for restraint and allow the patient to respond. The objectives of protective stabilization are to reduce/eliminate untoward movement, protect patient and staff, and facilitate treatment. Indications are patients who require immediate treatment and diagnosis and cannot cooperate due to lack of maturity or mental or physical disability or when the patient and/or dentist, staff, or parent would be at risk without immobilization. A third indication is sedated patients that require stabilization. Contraindications are a cooperative, nonsedated patient, a patient who cannot be immobilized safely due to an associated medical condition, a patient who has experienced past physical or psychological trauma as a result of protective stabilization (unless no other alternative is available) and a nonsedated patient with a routine treatment that would...
require an extended time in the dental chair. The latter two categories of patients were added in the latest revision, along with a section on precautions. The Academy advises careful review of the patient’s medical history, especially regarding respiratory function. Also, care should be taken not to restrict circulation or respiration. Careful evaluation and tightness of stabilization should be maintained throughout the procedure. Finally, the Academy recommends that a patient experiencing severe stress should have the stabilization terminated as quickly as is feasible to avoid possible psychological or physiologic trauma.

Southern Association of Institutional Dentists
The Association’s Self-Study Course Module 6: Managing Maladaptive Behaviors: the use of dental restraints and positioning devices is an excellent primer on the topic and list the characteristics of a dental restraint as:
- Short duration
- Limits movement of head, body, and extremities
- Prevents injury to patient and staff
- Generates enough physical control to allow treatment
- Is usually well tolerated by the patient

It lists the following criteria for patient selection for restraint: behavior, medical/physical condition, dental treatment needs, cognitive functioning/age, cost of alternative methods, sedated patients, protection of staff and patients, and external forces (i.e., legislation).3

Colorado State Board of Dental Examiners Board Policy 2004
Part 4J of the Colorado policy addresses medical immobilization/protective stabilization/restraint. It cites as the purpose of the policy to recognize the fact that pediatric and special needs patients may need to be medically immobilized in order to prevent injury and to protect the health and safety of the patients. It lists a training requirement beyond dental school, that may include a residency, graduate program, or extensive continuing education course that involves both didactic and experiential mentored training. The considerations, indications, and contraindications for medical immobilization are similar to the AAPD and include the safety of the patient, dentist, and staff.26

European Academy of Paediatric Dentistry
The EAPD Guidelines on Sedation in Paediatric Dentistry point out that restraint in dentistry including such restraining devices as the papoose board is practiced to varying extent in Europe, but in some places (such as the Nordic countries) is forbidden by law. A mouth prop may be used to help a child support the lower jaw and assist in keeping the mouth open, but may not be used to forcibly get a child to open the mouth. They note that use of a mouth prop may also make it difficult to address the sedation level of the patient.37

British Society for Disability and Oral Health
In Principles on Intervention for People Unable to Comply with Routine Dental Care restraint is defined (by the Department of Health in England) as: “the positive application of force with the intention of overpowering the person which is by definition without that person’s consent.” However, the term “physical intervention” is substituted to avoid the negative connotation of the word restraint.

It addresses varying degrees of restraint and “good decision making” about the indications, i.e., assessment for medical contraindications. It encourages the following:
- That a person “arc” over the patient so that the patient may still move freely
- Apply gentle pressure on extremities to not completely immobilize, but rather slow down movement
- Use a blanket to swaddle the patient

This last alternative is only used when there is an urgent need for treatment, the parental/guardian consents and the patient is unable to voluntarily comply with verbal requests and it is anticipated that they are likely to respond aggressively to any attempts to provide treatment.45

The society offers recommendations about physical interventions fashioned after Shuman and Bebeau’s publication of 1994.
1. The minimum to be effective
2. Clearly documented to include type and reason for use
3. Beneficial for the individual in completing the treatment
4. Not seen as a punishment or convenience
5. Not likely to cause physical trauma
6. Not likely to cause more than minimal psychological trauma
7. A means to avoid more severe forms of restraint, e.g., general anesthesia
8. To control involuntary movements
9. To avoid injury to the patient and/or others
10. Evidence of informed consent 55

This focus on patient autonomy is also evident in the Society’s published decision tree regarding capacity to consent in England and Wales. The decision tree for Scotland is far more complicated. This is not surprising considering that the Scottish Intercollegiate Guidelines Network “Safe sedation of children undergoing diagnostic and therapeutic procedures specialty requirements on dentistry state that “Physical restraints and HOM(E) have no place in dental treatment of children and should not be used.”58

Shuman and Bebeau
In their paper entitled “Ethical and legal considerations in special patient care,” they make the following recommendations regarding restraints:
1. The restraint is necessary for safe, effective treatment.*  
2. The restraint is not for punishment or the convenience of staff.*  
3. The least restrictive alternative is used.*  
4. The restraint should cause no physical trauma and minimal psychological trauma.*  
5. Reasonable benefits are expected as a result of the treatment.
6. There is consent for the dental treatment.
7. There is consent for the use of the restraint.
8. The restraint is specifically selected based on the planned treatment.
9. The dental staff is trained in the safe use of the restraint.
10. Restraint use is clearly documented, including type, duration, and reason for use.12
*(Shuman & Bebeau cite Fenton SJ. Revisiting the issue of physical restraint in dentistry. Spec Care Dentist 1989;9:1863 for recommendations 1-4.)

Academy of Dentistry for the Handicapped (now Academy of Dentistry for Persons with Disabilities)
The ADH ad hoc committee report: the use of restraints in the delivery of dental care for the handicapped-legal, ethical, and medical considerations stated the following regarding restraint:
- Physical or chemical restraint is a valid treatment modality for the noncompliant developmentally disabled patient.
- When using restraints, the least restrictive alternative should be employed.
- Physical or chemical restraint should not be used solely for the convenience of the dentist or as punishment for an uncooperative patient.
- The restraint must cause no physical injury and the least possible physical discomfort.
- The reason for use of the restraint, the type of restraint used, and the length of time administered must be documented in the treatment record.59

Summary of guidelines
Many of the published guidelines exhibit similar recommendations and suggestions. A summary of guidelines from the literature and complying with the federal legislation is outlined below:
1. Other alternative behavior management techniques should be considered prior to use of restraint.
2. Restraints should not be used for punishment.
3. Restraints should not be used for the conveniences of the staff.
4. Restraints should not cause physical harm to a patient.
5. Restraints should protect the patient and staff from injury during treatment.

Considerations:
- Dental treatment needs (i.e., extent of protocol)
- Effect on quality of care (e.g., poor quality restoration on moving patient, standard of care)
- Patient's physical condition
- Patient's emotional/developmental status (i.e., level of cognitive function)
- Avoidance of sedation/general anesthesia and associated risks

Documentation should include:
- Informed consent
- Reason for use
- Type of restraint
- Length of time used
- Other considerations may include:
  - More restrictive state statutes
  - Voluntary agency guidelines
  - Hospital or institutional regulations

Discussion
The concept of “least restrictive” environment is rampant throughout both the literature and the legislation on restraint. Part of assuring that the patient is treated accordingly is to consider alternative methods to restraint.

The degree of management difficulty in the dental operatory is usually inversely proportional to the level of the individual’s cognitive functioning.7 Severe cognitive and communication deficits of patients with severe/profound mental retardation make it difficult for them to benefit from behavioral modification techniques such as desensitization. For this particular segment of the population, restraints are often required for dental treatment.9

Still, desensitization may be considered for some patients with challenging behaviors. For patients with more severe and profound cognitive deficits, the desensitization program may only serve to calm the patient and desensitize them to the restraint through repeated exposure.60 (This modality can at least be tried, with the first visit to the dentist serving as an introduction, in which no actual dental treatment is provided.)4 This orientation to a new place may help to decrease a patient’s anxiety on subsequent visits.

Other interventions such as enhanced distraction, contingent distraction, filmed modeling, and reinforced practice have been documented in the pediatric literature, but require cognitive participation by the patient.61

No single behavior management technique is appropriate for all patients with special needs. For patients requiring restraint, the practitioner should evaluate all the relative variables and decide on the least restrictive and most effective method. One must balance the perceived risks with the perceived benefits.

Consideration of the patient’s past behavior in the dental environment is an important consideration in the evaluation for restraint.

Obtaining informed consent for both dental treatment and restraint presents special challenges for patients who do not have legal capacity. It is important that open lines of communication between the practitioner and parent or guardian are established. Informed (guardians) are more likely to approve the use of restraints.39

The 2000 Surgeon General’s Report and subsequent National Call to Action demand oral health care for this most vulnerable population.20,21 If dentists are not permitted to employ appropriate use of restraint, surely many people with special needs will either not receive necessary care or may be subject to needless general anesthesia at a much greater risk to their well being. Certainly, sedation or general anesthesia are not reasonable means of delivering daily oral hygiene, recall exams, or minor restorative treatment.39 Ethically, the dental profession has an obligation to provide care to all segments of the population who seek it, including the developmentally disabled, aged, and institutionalized.49,50 Dentists are responsible to report signs of abuse and neglect in patients, including dental neglect.
Providers must be sure to advocate for patients and not support a case of “supervised oral neglect” due to perceived or real administrative barriers to care.
CONSENT, RESTRAINT, AND PEOPLE WITH SPECIAL NEEDS

Practitioners also need to develop working partnerships with long-term residential agencies to better the quality of oral care. The interpretive guidelines for ICFs recommend that the dentist participate in the development of the individual’s program plan. In the plan, the dentist can document recommendations and rationale for behavior management techniques such as medical immobilization and/or sedation. This may be a way to establish better communication between dentist and administration. Perhaps by documenting guidelines and coming to a consensus, the Special Care Dentistry Association can assist in breaking down some of the administrative barriers that exist in this area.

Conclusion

Dentists, agencies, caregivers, and guardians are all on the side of the patients. We must work together to ensure that the patients’ rights to oral health is balanced with patients’ rights as human beings. We must assure patients and families that we are doing all we can, in the best interest of our patients to deliver safe, quality dental care in the most comfortable environment possible. It is our job as practitioners to educate families, patients, and guardians to understand the safest alternatives and to help them in the decisions regarding oral health. While patients have a right to autonomy, we have a duty as doctors to give them the best care that we can.

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Romer
CONSENT, RESTRAINT, AND PEOPLE WITH SPECIAL NEEDS


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