Ask the Ethicist

Is It Ethical to Sedate this Patient in the Pediatric Intensive Care Unit for Behavioral Problems?

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ABSTRACT

Children with complex developmental disorders are often difficult to care for in the environment of the hospital. This is particularly true when there are unsafe behaviors such as physical outbursts or self-injurious actions. Out-of-hospital placement has been increasingly challenging, which leads to prolonged hospitalizations, a further challenge to the provision of good care. This "Ask the Ethicist" column responds to the complex question of how to best care for a child and balance possible immediate harms to the child and staff with possible long-term harms. Clinical ethicists respond to the case and question and provide an analysis and recommendations for this difficult situation.

CASE

Alex was a 16-year-old child with autism spectrum disorder, intellectual impairment, oppositional defiant disorder, anxiety, and type 2 diabetes. When upset, Alex engaged in self-injurious behavior through head-banging as well as violence towards others through hitting. He was a ward of the county and had been rejected from several group homes due to his unsafe behaviors towards other residents.

He was admitted to the hospital with an acute illness and then remained hospitalized because no safe discharge plan could be formulated. He had been hospitalized for two months. His medications included sertraline, trazadone, atomoxetine, extended release amphetamines, extended release guanfacine, ziprasidone, olanzapine, extended release valproate, and hydroxyzine. He required frequent behavioral interventions such as physical restraint. He injured several staff members.

Staff were frustrated because there seemed to be no alternative housing to be found for Alex. Each day he required several staff members to de-escalate his behavior and he often had to be restrained. He often became violent when restricted from any foods, but the medical team was worried that his obesity and type 2 diabetes impacted his health, and believed that not restricting his diet would be harmful. Staff members were concerned about the safety of

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the patient, themselves, and other patients, as well as the large amounts of resources Alex required in the context of a staffing shortage. The Pediatric Intensive Care Unit (PICU) physician was asked whether they would sedate Alex in the PICU. The PICU physician consulted with clinical ethics to ascertain whether this was ethically appropriate.

THE CLINICAL ETHICISTS' ANALYSIS

Cases like Alex's are becoming all too regular in children's hospitals. The increase in hospitalizations for mental health was growing before the COVID-19 pandemic. The pandemic worsened the health of children with complex developmental and psychological needs because it interrupted their daily structure and individualized educational and care programs. Parents may find themselves unable to safely provide the structure, treatment, and care required to provide their child with a safe and healthy life. For children with extreme care needs such as Alex, it is difficult to find a placement in long-term care. Often children's hospitals are not therapeutic and can only provide a safe environment for these children until an appropriate facility is found.

Children with autism or behavioral issues may be sedated in the PICU to control their behaviors, but this is generally for the toleration of a medically necessary treatment or related to an acute issue such as delirium or psychosis. But Alex's aggressive behavior was related the restrictions imposed by his prolonged hospitalization and his underlying issues; problems that would not be resolved by sedating him for a brief period of time. Quite the opposite: increasing the intensity of his care would likely have made finding suitable long-term care for Alex much more challenging, because outside facilities would see his behaviors as impossible to manage without ongoing sedation.

The repeated need for physical restraint can be hazardous to a patient as well as to staff. The primary benefit of moderate sedation was reduced physical and/or short-acting chemical restraint, since every restraint event presented a risk for physical harm for all involved. However, the harms of moderate sedation also needed to be considered. The use of dexmedotomidine was considered. It is often used in situations when a child requires sedation to tolerate medical interventions, as it can be used without the need for invasive respiratory support. While the drug minimally depresses respiration, it has cardiovascular effects, primarily bradycardia and hypotension. Furthermore, dexmedotomidine, as a single agent, may not be provide enough sedation to prevent aggressive behaviors, particularly for patients like Alex, who have been chronically exposed to other $\alpha 2$-adrenergic agonists such as guanfacine or clonidine. Alex might have required stronger sedatives with more respiratory depression, which could have risked the need for intubation.

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Sedating Alex would reduce the possibility of harm and injury to the staff, and would make staff more available to care for other patients. On the other hand, it would require a PICU bed and staff, which are limited resources. Sedating Alex to benefit staff and other patients would be an unjust violation of the expectation that all patients should receive beneficent care, and would undermine the goal of a long-term care placement for Alex.

Escalating to moderate sedation would not be indicated and would be unethical, as difficult as that would be for the staff. The clinical ethicists recommended that the institution find alternative strategies to support Alex and the team to reduce risks to Alex and honor his right to fair and appropriate treatment.

THE CLINICAL ETHICISTS' RECOMMENDATIONS

In this difficult case, the focus should be solely on the interest of the patient. If Alex had acute psychosis or delirium, short-term moderate sedation could have provided a medical benefit and so could have been ethically appropriate. But sedating the patient to address longstanding behavioral concerns that would not be relieved by the sedation would not benefit Alex and therefore was not a patient-centered goal.

Staff have a right to be safe in their workplace, and the care they offered Alex was affected by the risk he posed to them. Still, efforts to improve the safety of staff must weighed by how it would affect the care Alex received.

Some of the patient's behavioral outbursts could have been related to the staff's efforts to restrict his diet. While long-term health concerns such as glycemic control are valid and appropriate, perhaps the team could have considered less-restrictive control of his food to reduce the greater and more immediate harms of his behavioral outbursts and a subsequent need for restraint.

It would be important to understand and consider Alex's quality of life, if possible. If he was unable to express himself, it would be important to identify those who made decisions for him, or those who knew him best, to develop some goals of care.

Physical restraints should always be a last resort. Use of restraints should always start with least-restrictive means in accordance with standards of practice set by the American Nurses Association and the American Psychiatric Nurses Association.[1] Four-point restraints and short-acting chemical restraints would have been ethically appropriate methods of behavioral control for Alex when other means failed and no other means were available. The team should consult with psychiatry to consider tailoring the patient's baseline medications to achieve better stability. Psychosocial teams such as behavioral health, child life, and others should be consulted to formulate strategies to support Alex and the staff. The urgent need for long-term placement should be escalated to hospital leadership.

CONCLUSION

Unfortunately, we will continue to deal with the inadequate social resources, due to the shortage of adequate long-term residential care. Individual cases will continue to be difficult and distressing because some problems cannot be solved at the bedside. Institutional and governmental intervention is needed to increase resources for long-term care and supportive home options to prevent children from requiring long-term care, when possible.

In the meantime, hospitals must adapt to deal with new challenges, particularly when they include the safety of patients and staff. Hospitals must support staff who will bear much of the moral and physical burden of insufficient social resources. Providing a medical intervention that does not benefit a patient to potentially benefit the hospital and staff is not an ethical solution to a complex problem.

ANONYMIZATON OF THE CASE

The details of this case have been changed to protect the privacy of the patient and family.

NOTES

1. Center for Ethics and Human Rights, American Nurses Association, "The Ethical Use of Restraints: Balancing Dual Nursing Duties of Patient Safety and Personal Safety," 2020, *https://www.nursingworld.org/~48f80d/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/nursingpractice/restraints-position-statement.pdf;* American Psychiatric Nurses Association, "Standards of

Practice: Seclusion and Restraint," 2022, *https://j5j4t1di1k72gkoj83kbird1-wpengine.netdna-ssl.com/wp-content/uploads/2022/03/APNA-Standards-of-Practice-Seclusion-and-Restraint-2.2022.pdf.*