Ethical Considerations of Video Monitoring Psychiatric Patients in Seclusion and Restraint

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Video monitoring of psychiatric patients in seclusion and restraint is reviewed from ethical and legal perspectives. Video monitoring invades privacy beyond patient expectations for routine hospital care and has the potential to harm personal dignity. The potential benefit of patient safety through monitoring must be balanced with the potential harm of monitoring to provide ethical justification. Because involuntary monitoring places patients in a position of extreme vulnerability to personal exposure, clinicians are obligated to protect these patients. A case illustrating problems with video monitoring along with recommendations for ethical use of video monitoring are presented in this article.

PSYCHIATRIC PATIENTS in seclusion and restraint are often monitored by video camera to improve patient safety and assist nursing staff in meeting observation standards required by law and hospital policy. Video monitoring in a nonpublic space is, under normal circumstances, an unacceptable intrusion and invasion of privacy. Although psychiatric hospitalization is not a "normal" situation, patients in restraint and seclusion may still experience video monitoring as embarrassing and intrusive, adding to a stressful situation. Other factors adding to the ethical complexity of video monitoring are:

1. The patient is physically prevented from leaving the area under surveillance.
2. The patient may be compelled to wear hospital garb.
3. Some patients may desire and be comforted by the monitoring whereas others may feel violated.

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Ethical and legal justification for placing unwilling patients in restraint or seclusion currently requires a demonstration that such action is the least restrictive effective treatment available (Olsen, in press). This article develops guidelines for the ethical justification of adding video monitoring to a restraint-and-seclusion situation by reviewing potential benefit and harm from monitoring, then presenting a clinical case followed by a discussion of the ethical and legal aspects of privacy.

POTENTIAL BENEFIT AND HARM IN VIDEO MONITORING

Video monitoring influences two aspects of personal identity: self-presentation and privacy. Attempts to control the way one is viewed by others is a central mechanism of personal identity and serves as a basis for social relations (Bok, 1983; Goffman, 1973). Privacy is needed to develop and maintain a sense of personhood (Reiman, 1984). Self-presentation and privacy are related—privacy provides an individual with a boundary between self and others, and allows limitations and controls to be placed on what is presented publicly and to selected others. Privacy also allows one the opportunity to express characteristics and desires that one would not wish to reveal to others. An inability to maintain some secrecy about aspects of

the self can result in a profound loss of identity (Bok, 1983). When others view behaviors or characteristics one considers private, embarrassment and shame are experienced (Lynd, 1958, Levy, 1983). The experience of shame and embarrassment from public exposure of the private is a cross-cultural phenomena (Levy, 1983) and virtually all cultures have some accommodation for individual privacy (Moore, 1984).

Monitored patients lack any semblance of privacy and have a severely limited opportunity to control self-presentation while under continuous observation, not knowing who is watching and when. This constraint is in addition to any difficulties the person is having in controlling self-presentation because of a psychiatric disorder. Knowledge of the monitoring could enhance a sense of shame in patients unable to regulate self-presentation because of a psychiatric disorder. Clinicians are expected to respect a patient's autonomy to regulate access to personal space and information unless there is specific ethical justification to override patient autonomy (Beauchamp & Childress, 1994). Monitored patients are denied this autonomy, thus justification is required. The need to ethically justify video monitoring is highlighted by the denial of privacy used to deteriorate the mental state of political prisoners (Caplan, 1982).

In psychiatric patients, the denial of autonomy over some treatment decisions should already be justified to allow the restraint or seclusion. The addition of video monitoring is ethically justified by balancing the good of monitoring with the negative aspects. Patients under surveillance may be safer from violent or self-destructive impulses, but are vulnerable to loss of privacy and personal exposure. A potential loss of benefit emerges if the patient loses human contact with the nursing staff because observation and assessment occur from a remote location.

Patient factors also affect the balance because patients will experience varying degrees of intrusion; some will even welcome and be comforted by monitoring. If patients were given a choice over monitoring, the choices would likely vary. In the related situation of psychiatric restraint, Sheline and Nelson (1993) showed that patients' perceptions of the desirability of different restraint methods varied by finding that 10% of psychiatric patients preferred physical over chemical restraint. An all-encompassing hierarchy of forced treatment techniques, including video monitoring, is not possible because of the variability in what people experience as intrusive.

Another ethical aspect of video monitoring is that the patient is made more vulnerable to exposure. Among the risks of unwanted exposure are shame, loss of privacy, and a loss of confidentiality. Furthermore, the decision to create the potential for harm through exposure is not in the patient's control. Therefore, clinicians have an obligation to minimize the consequences of the added exposure and protect the patient from any of the potential harms of monitoring.

In summary, a decision to video monitor a patient should balance potential harm from loss of privacy, exposure, loss of human contact with nurses, breach of confidentiality, and associated feeling of embarrassment and shame with the potential good of increased safety and efficient use of staff resources, tempered by a clinical appreciation of individual patient factors. If a decision is made to monitor, all involved clinicians have a clear obligation to protect the patient and minimize the potential for harm.

CASE EXAMPLE

The following case is based on an investigation of a complaint filed with a state office of protection and advocacy by a woman protesting the decision to put her in locked seclusion in a hospital emergency room. This example includes elements from other cases involving video monitoring investigated through the same agency. The client learned about the video monitoring several months after the incident during the course of investigating the initial complaint. The case includes other elements that were ethically questionable, prompting the investigation. However, the potential for harm in video monitoring was shown by the patient's declaration that, for her, this was the most offensive element of the incident.

> Mary is a 24-year-old woman brought to the emergency department (ED) by her parents. Mary had telephoned her parents earlier saying that her depression was particularly severe. In this telephone call she initially denied feeling suicidal, but later admitted thoughts of suicide and revealed that she had stored a large amount of discontinued medications for this purpose. She reluctantly agreed to go to the ED when the parents threatened police intervention.
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> In triage she reported, "bad depression and suicidal feelings," but specifically denied past suicide attempts.

Before leaving, her parents told the psychiatrist that Mary had two prior hospitalizations after potentially lethal overdoses. After triage Mary was placed in a hospital gown as per hospital policy with psychiatric patients in the emergency room. The intent of the policy is to make elopement more difficult. She was uncooperative with this procedure and remained belligerent for some time.

A decision was made to offer Mary admission and to commit her if she refused. She refused angrily and asked to leave. She was considered an elopement and suicide risk because of her history of serious suicide attempts, uncooperative behavior, and the deception about her history. She could not be transferred to a secure inpatient unit at that time because the hospital's locked psychiatric unit did not have an open bed. The search for a bed in another hospital would take time. The ED did not have enough staff available to provide Mary with continuous personal observation, and she was placed in locked seclusion.

Mary was observed by video monitor while in seclusion. The camera was recessed into a wall and easily overlooked. One monitor was at the reception desk visible to the admitting clerk and others passing into the clinical area. Another was visible in the security office.

Hospital policy mandated 15-minute checks and offers of nutrition and toileting every other hour. The checks not involving food or toileting were made by the video monitor. Mary was in the seclusion room under surveillance for 8 hours.

PRIVACY AS AN ETHICAL CONCEPT

Three concepts relate to ethical issues of privacy: a sense of privacy, control of privacy, and the right to privacy (Beauchamp & Childress, 1994). The patient's sense of privacy may not accord with reality. A paranoid patient might feel under observation even when not actually being monitored. Mary had a sense of privacy while in seclusion, but was actually under observation. People may feel particularly violated when they find out that they were observed during a period when they believed themselves to be alone. A patient might not be told about the monitoring with the justification that it would cause unnecessary anxiety. This requires the further step of justifying a paternalistic deception. This type of deception shows a fundamental lack of respect for the patient. Even with benevolent intent, the clinician cannot accurately predict the consequences of the lie (Beauchamp & Childress, 1994). The likelihood that a patient would discover the deception and feel doubly betrayed is high on an inpatient unit. In Mary's case she discovered the monitoring after the fact, although the deception was unintentional.

Achieving privacy may not be under personal control. A person may have privacy because of unwanted social isolation (Caplan, 1982). In the case of video monitoring, the patient has no control over a lack of privacy. In normal circumstances a right to liberty allows a person to retreat into privacy at will. Even though curtailed in the hospital, most inpatient psychiatric programs allow patients some discretion in choosing private and social situations.

The right to privacy is the ethical concept that individuals have some right to control access to personal areas (Goldstien, 1990). The two areas of privacy related to mental health care are access to personal information and access to personal space (Goldstien, 1990; Wiener & Wettstein, 1993).

The right to privacy is derived from individual autonomy and the right to liberty. Persons are accorded the right to control access to themselves and to personal information as a function of being autonomous agents (Beauchamp & Childress, 1994).

PRIVACY AND THE LAW

Two legal aspects to video monitoring patients are a legal right of privacy and laws regulating covert monitoring.

Right To Privacy

Although the constitution does not specify a right to privacy, the Supreme Court, beginning with Griswold vs. Connecticut in 1965, has held that privacy is protected by the first, third, fourth, fifth, ninth, and fourteenth amendments (Beauchamp & Childress, 1994). In 1974 the federal court's decision in Wyatt vs. Stickney stated that psychiatric facilities should, "promote dignity and ensure privacy" making a right to privacy explicit for psychiatric inpatients (Wiener & Wettstein, 1993). After this decision, most states mandate the protection of patient privacy (Wiener & Wettstein, 1993). A patient in a psychiatric hospital can expect less privacy than when not in the hospital, but clinicians are bound to provide whatever measure of privacy is safe and available.

Legal Regulation Of Covert Monitoring

It is illegal in many states to record a person who is unaware when there is an expectation of privacy. The expectation of privacy is based on the context (Larmouth, Murray, & Murray, 1992). For example one can expect privacy in the restroom, but not waiting in line at the bank. In Gallella vs. Onassis,

the court held that unwanted photographing from a distance violated the right to be left alone (Larmouth, Murray, & Murray, 1992). Litigation has also been pursued by patients who discovered they were recorded for research purposes (Allan, 1995).

The expectation of privacy is ambiguous in the context of a hospital room where psychiatric care is being provided. The statutes and court rulings in states that outlaw recording apply to covert surveillance, and assume that when people are notified, they can exert control by granting permission or removing themselves. Patients in restraint and seclusion, however, are compelled to undergo monitoring regardless of their wishes.

Claims based on the invasion of privacy through electronic monitoring require that the purpose of the monitoring be criminal, tortious, or injurious to the nonconsenting person (Larmouth, Murray, & Murray, 1992). Video monitoring for patient safety would exempt the clinician from such claims provided the loss of privacy is minimized and adequately justified by the potential harm of not monitoring.

RECOMMENDATIONS

1. Document a clinical justification for monitoring as loss of privacy at the same time seclusion or restraint is justified as a denial of liberty. The record should indicate that a monitor is in use and the reasons for its use. This adds little documentation burden as clinicians are already required to justify the use of seclusion and restraint in a way that balances the loss of liberty with safety (Alexander, Bursztajn, Brodsky, Hamm, Gutheil, & Levi, 1991).
2. Inform patients that they are being monitored. This allows patients to adjust self-presentation accordingly within the limits of their mental disorder. Patients may not have the option to decline monitoring, but they have a right to know why the monitor is being used and under what conditions the monitoring will be discontinued. Patients have similar rights regarding restraint and seclusion (Olsen, in press) A sign in the seclusion room may be helpful to patients who, because of their psychiatric condition, are unable to attend to a verbal message regarding monitoring. The sign should be removable so that patients who are not on camera are not deceived.
3. Place monitors where they can be viewed only by staff with direct clinical responsibility. This will help contain breaches of confidentiality and reduce the potential for embarrassment to the patient.
4. Give careful consideration to who is responsible for watching the video monitor for changes in patient status. Staff lacking clinical training should not be assessing unstable patients. Patients should not lose the benefit of good clinical care because they are being video monitored. This is part of the clinician's protection of the patient who is forcibly placed in a vulnerable position.
5. Viewing the monitor does not substitute for direct visual inspection and human contact with a nurse. Documentation should distinguish direct visual inspection from checks performed by monitor. Many conditions that would be apparent by visual inspection could go unnoticed on a monitor (e.g., pallor or stupor rather than sleeping). Providing the patient with human contact through good nursing care is both respectful of personhood and a clinical benefit that should not be lost because of video monitoring. This also helps to fulfill the obligation to protect these patients.
6. Maintaining a personal relationship with the patient remains the most ethically appropriate action and the best liability protection, even in the extreme circumstance of seclusion and restraint.

CONCLUSION

Video monitoring psychiatric patients in seclusion or restraint is a technique that can improve the safety of these interventions. The same video monitoring can also be an intrusion forced on patients with the potential to cause harm. Ethical treatment means balancing the good of a safer environment with the potential of harm from a loss of privacy. When the decision is made to video monitor a patient, nurses have a duty to minimize the potential harm, protect the patient, and not diminish the benefit of personal care given by a nurse.

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