

**MEDICAL EDUCATION: PEER-REVIEWED ARTICLE**

**How Should Trainees Be Taught to Have Compassionate Intention When Force Is Necessary to Care Well for Patients?**

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**Abstract**

Trainees are expected to encounter clinical training environments and situations that utilize methods of force as a component of clinical care. These include emergency care, critical care, and psychiatry. Several educational recommendations are offered in this paper related to these situations—including de-escalation training and crisis management skills, trauma-informed care, person-centered care approaches, and compassionate care approaches—to support trainee development across clinical care settings. Trainees require supervisors' focused attention to consider and implement force when caring for a diverse range of patients and retraumatization risk. Minimization of the need for forced care and the implementation of compassionate force in treatment require thoughtful and comprehensive educational plans.

**Force Interventions in Clinical Care**

*Dr Gutierrez, your patient is not redirectable and has been insisting on leaving the hospital. They have been going close to the exit doors and have been yelling and are disruptive on the unit. I've tried talking with them, but there's no way to convince them that they should remain in the hospital. They started banging on the walls and just now were banging their head on the wall. I'm concerned about their safety and think they should be restrained.*

This is just one example of a clinical scenario that might occur during training, wherein patients exhibit unsafe behavior toward themselves and require intervention ordered by the clinician. In fact, consideration of the use of force in treatment is an issue within emergency departments (for verbal abuse, threats, physical assaults, assaults with bodily fluids, and aggressive behaviors)<sup>1</sup>; inpatient psychiatry (for behavior that is self-injurious or aggressive or threatening to others, physical assaults)<sup>2</sup>; critical care (for agitation, self-extubation, removal of arterial and venous lines, declining life-saving treatment)<sup>3</sup>; and other areas of health care training.

Force is considered as any intervention that is initiated by the clinical team and is provided without the consent of the patient. The Joint Commission defines physical restraint—one method of force used in clinical care—as “any manual method or physical

or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's condition."<sup>4</sup> By definition, these types of interventions are delivered by health professionals who make a clinical determination that the intervention is required to reduce the risk of physical and psychological harm of prolonging an urgent decompensation.

The frequency of forced care varies by cultural context, patient demographics, and clinician. Depending on the country, the use of force in inpatient psychiatry admissions in the early 2000s ranged between 1.2% (the Netherlands)<sup>5</sup> and 8.0% (Germany).<sup>2,6</sup> In one Norwegian hospital, immigrants (21.6%) were more likely to be restrained than native persons (12.9%),<sup>7</sup> indicating potential clinician bias or at least significant challenges in clinicians' application of alternative care practices in the care of minority patients. Clinician attitudes toward forced treatments also have an impact on the culture of a health care setting. In one 1996 study, 20% of critical care nurses believed that restraints were acceptable if no person was available to monitor a patient.<sup>8</sup> More recently, various interventions have been successful in reducing the rates of forced care procedures within health care environments.<sup>9</sup> Several educational recommendations are offered in this paper related to behavioral emergencies—including de-escalation training and crisis management skills, trauma-informed care, person-centered care approaches, and compassionate care approaches—to support trainee development across clinical care settings.

### **Behavioral Emergencies**

Behavioral emergencies are highly complex and require the clinician in training to determine in the moment whether to assert the use of force—an intervention reserved only for the most extreme clinical situations—or to use alternative interventions to address the patient's distress. When clinicians recognize patient distress early in the development of a behavioral emergency, the delivery of nonforceful interventions is not only possible but preferred over forced interventions. A trainee is prompted to decide whether to use such an intervention and, if used, the type of restraint and how to deliver it in a manner that attempts to convey compassion and support. Restraints can be medicinal, mechanical (eg, leather straps, restraint chair) or physical (eg, physical touching or holding by clinicians to restrict movement of a patient).

Behavioral emergencies, including patient violence, and the consequent use of force can result in negative outcomes. While these emergency situations can be associated with intense emotional distress, they can be traumatic not only for the patient but for a trainee.<sup>10</sup> For the patient, forced treatments result in a loss of independence and agency and risk both physical injury and psychological injury, including shame, fear, and anxiety. Force can result in patients' distrust of clinicians and deterioration of the patient-doctor relationship. For a trainee, behavioral emergencies are associated with the risk of potential physical and psychological distress if interventions are not delivered in a safe manner by an interdisciplinary team.<sup>11</sup> Therefore, there are ample reasons to work to reduce the frequency of and provide education on the application of forced treatment.

Behavioral emergencies occur within various clinical care settings and require consideration of forced care interventions to protect the patient and staff. It is the process by which a trainee learns how to approach these emergencies that can lead to a **compassionate approach**—through attention to the individual patient, the clinical

context, and alternative interventions. In essence, seizing opportunities to educate and support trainees in making informed decisions about care during behavioral emergencies is essential to the development of future compassionate and ethical attending clinicians. Although the procedures might be delivered only during behavioral emergencies, the educator has ample opportunity to educate and train students in various aspects of the use of force prior to behavioral emergencies. These opportunities can allow for shaping trainees' approach to and delivery of emergency interventions and the aftercare associated with them. Close attention to training in the approach to emergency use of force in treatment has the potential to reduce the risk of distress for the patient and for trainees.

### **Educational Framework Recommendations**

Training opportunities should center on the overarching goal of reducing the overall prevalence and negative outcomes of force within health care. Below are 4 specific goals for educators working with trainees.

*Minimize the use of force overall.* A trainee should be provided with de-escalation training and crisis management skills applicable to clinical care.<sup>10</sup> This training should provide the trainee with information about how to identify patients who are in acute emotional or physical distress, how to respond with awareness, and how to deliver effective strategies to promote containment of a behavioral emergency without the need for more invasive interventions that include forced restraints. Trainees would learn that there are alternatives to forced interventions that are effective and that utilize the entire treatment team's skills and resources during situations that lead up to behavioral emergencies. Alternatives to force include clinician and other staff support through active listening and problem solving, sensory tools (eg, music, stress balls), as-needed medication, decreasing environmental noise, and offering access to family or other peer supports outside the hospital. Modeling of compassion by attending clinicians and support staff is also highly important to promoting the reduction of restraints and seclusion.<sup>12</sup> Many trainees don't expect to encounter these situations in their training environments, believing erroneously that they are circumscribed to specific hospital or clinic settings with specific populations. In fact, trainees benefit from learning from allied health professionals—such as occupational therapists, nurses, and psychologists—who have expertise in sensory and cognitive-behavioral approaches that can aid in the assessment and reduction of risk of behavioral emergency escalation.<sup>13,14</sup>

*Minimize the effects of retraumatization.* The educator has a responsibility to provide training and education on the importance of provision of care through a **trauma-informed care** lens. Trauma-informed care is described by the Substance Abuse and Mental Health Services Administration as “a program, organization, or system that is trauma-informed; realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.”<sup>15</sup> Trainees benefit from information on trauma and its impact on people's psychological health and behavior. Treatment that is forced has the potential to be traumatic in and of itself, and so the educator is called upon to provide the trainee with an understanding of how to provide emergency interventions—which may include force—in a way that aims to minimize the potential for retraumatizing the patient. These strategies may include offering clear and direct choices, using a calm tone of voice, and minimizing the length of time in restraints.<sup>16</sup> Additional educational opportunities

include debriefing with the patient after the event to discuss the forced intervention and considering ways to reduce the likelihood of using force in future care of the patient.

*Emphasize humanization of patients.* Education that integrates a **person-centered approach** enables a trainee to understand that a patient's behavior might be a response to their distress and might not define who they are as an individual. Understanding that the patient's behavior is a response to distress or a feature of an illness can help a trainee tap into their sense of humanity in providing care. Person-centered care facilitates the clinician's appreciation of the patient's autonomy, capability, and personhood. Recognition of the patient's personhood and humanity then enables the clinician to actively join the patient in understanding the patient's experiences and needs.<sup>17</sup> The clinician should also understand the patient's strengths, rights, autonomy, and preferences for care as well as review, if available, the patient's psychiatric advanced directive indicating treatment preferences during psychiatric emergencies.<sup>18</sup>

*Promote compassionate care.* A trainee's care of the patient is enhanced when a compassionate approach is emphasized.<sup>19</sup> Specifically, patients prefer a patient-clinician relationship that includes features of trust, fairness, and consistency. Behavioral demonstrations of empathy, respect, courtesy, attentive listening, reassurance, sincerity, genuine concern, and validation of the patient's experience are specific actions by which a clinician can promote a compassionate relationship with the patient. The clinician must establish an emotional connection to the patient's experience while recognizing the existence of and opportunities to overcome risks of exhaustion, burnout, and numbing.<sup>20</sup> Helping trainees to connect to the suffering of the patient can allow them to understand the importance of how they deliver care. In particular, helping trainees transform a *What's wrong with you?* approach into a *What can I do to help you?* approach emphasizes that the patient's behavior expresses a need, and this approach will ultimately help them cultivate a compassionate care style in practice.

### **Diversity Factors and Force of Care**

The use of force in health care can best be delivered when it is contextualized for each patient, as its implications may be highly variable depending on patient demographics and history. Training should integrate a focus on understanding the patient's identity on multiple levels with how implementation of forced care might be influenced by who they are and what they have experienced. Although it is impossible to know or understand all the unique experiences or characteristics of an individual patient, trainees need to learn what factors are reasonable to consider and how to seek information—including by asking more questions of a patient—prior to any behavioral emergency so that this information is available to consider in an emergency. Factors that are pertinent to consider include race, ethnicity, age, sexual orientation, and gender identity, as well as a history of interpersonal or other traumatic events, including sexual, physical, and emotional abuse, among other factors. For example, the forced restraint of a young adult Black male who had been the victim of police brutality 2 years prior to presentation at the hospital presents a clinical care situation that includes high risk for retraumatization, particularly if force is used by trainees who are White men and by attending physicians, security personnel, and other staff, given reported high rates of police violence and their associated mental health impact on Black individuals.<sup>21,22</sup> Similarly, sexual abuse victims may experience increased rates of distress with forced care that does not allow them to have full control over their body or that is conducted by trainees or staff who are of the same gender as the perpetrator(s). Sexual and gender

minorities are subject to high rates of previous trauma, and thus forced care can be especially traumatizing for these persons, who already are mistrustful of the health care environment.<sup>23</sup> While all information relevant to a specific patient's identity and experience might not be known to clinicians during a behavioral emergency, aggregate patient preference data based on these factors are increasingly used in decision making in situations when timely availability of patient information is not possible.<sup>24,25</sup> In addition, psychiatric advance directives, which formally document patients' care preferences prior to an emergency situation, can inform clinicians of patient preferences.

If trainees are required to use forced interventions during behavioral emergencies for a person who is at high risk for retraumatization, it is important for the trainee to state clear intentions for the use of the intervention, maximize efforts to promote dignity (eg, maintain clothed body), **ensure supportive clinicians are available** at all times if safe and appropriate, and offer to engage in debriefing with the patient afterwards to determine how to minimize the need for such an intervention in the future. In addition, it is important to connect the patient with supportive clinicians, including those who specialize in mental health.

### **Experiences of Trainees**

Because trainees can be affected by witnessing, participating in, or ordering forced treatment, educators must attend to the impact of the intervention on trainees. Although there is a dearth of research in this area, it is necessary for supervisors to attend to the experience of the trainee when considering and implementing force within treatment. Supervisors have an opportunity to assist a trainee in understanding how to make highly challenging and complex clinical and ethical decisions during behavioral emergencies, implement trauma-informed and person-centered care approaches, and provide compassionate care. While the goal of forced treatment is to preserve the safety and health of the patient and others, a trainee can benefit from opportunities to engage in patient and treatment team debriefings about the events as well as their own debriefing. Follow-up support from supervisors and administrative leadership humanizes the training environment and provides opportunities for trainees to learn how to manage future behavioral emergencies. While we know of no research on this topic, it is possible that a lack of compassionate supervisory support in this setting could further traumatize trainees.

### **Summary**

In conclusion, an educational and training program for trainees on force in health care ought to attend not only to delivering compassionate forced treatment but to minimizing the use of force practices. Training programs that regularly attend to development of de-escalation and crisis management skills within both trauma-informed and person-centered clinical approaches will develop clinicians who have the capability to provide compassionate care when force is required. Attention to possible bias and careful consideration of the appropriateness of force and the methods by which force is applied, especially in members of minority and marginalized groups, is essential. Finally, it is important for educators to acknowledge the professional and personal experience of the trainee when engaged in making such decisions in order to provide structured support that is empathic and understanding. With comprehensive education and training initiatives, trainees will learn not only how to effectively deliver forced treatment but how to ensure that it is minimized and utilized in the most judicious and compassionate manner possible to preserve the rights, autonomy, and well-being of all patients.

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