

Compassionate Force

April 2021, Volume 23, Number 4: E287-370

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AMA Journal of Ethics®

April 2021, Volume 23, Number 4: E289-291

FROM THE EDITOR

Force and Compassion in Health Care

Arya Shah, MD

I began synthesizing this theme issue and writing this letter amidst the reality of mandatory physical distancing, enforced mask wearing, and required sheltering in place. *Force* as a topic in health care took on new meanings during the 2020 COVID-19 pandemic, with society trying to balance public health obligations against individual liberties. Force in health care and public health is not new. Although public health measures apply and exert force differently than bodily applications of force through physical, chemical, or legal restraints on a patient's liberty, both public and personal applications of force can be understood in terms of our intentions, our responsibilities as citizens and professionals to motivate common good, and our interest in protecting the most vulnerable among us.

Restraint use began hundreds of years ago to give officials legal authority to contain individuals thought to be disturbing the peace. Since then, policies and procedures have evolved; by the 1960s, movies like *One Flew Over the Cuckoo's Nest* were bringing public attention to the use of physical and chemical restraints—specifically, in mental health care. The Joint Commission and the Centers for Medicare and Medicaid Services have since established guidelines for using restraints in clinical settings, which emphasize patients' rights to be free from restraint or seclusion except in cases of endangerment to the patients themselves or to others.^{1,2}

Using force is frequently justified in health care when the risk of harm is thought to be outweighed by potential benefits. Obtaining court approval (a legal means of force) for emergency electroconvulsive therapy in a psychotic patient with catatonia, for example, might be lifesaving. The hope that force of any kind might save patients' lives, spare them injury, or spare them anguish is one reason why we even consider force as ethically justifiable and may be even the most compassionate thing professionals can do for patients in some circumstances. However, maximizing the chances for an intervention's benefit while simultaneously minimizing the risk of adverse consequences isn't easy and, in some cases, might **not even be possible**.

Clinicians are faced daily with situations like these, which necessitate rigorous contemplation of how best to balance patient and staff safety with patients' human rights and dignity. Given that physical, pharmaceutical, or other means of force, even when justifiable, can **undermine the therapeutic alliance** in patient-clinician relationships,^{3,4} erode trust among patients,^{5,6} or exacerbate moral distress among staff,^{7,8,9} the clinical and ethical stakes are high.

Because of these stakes and the extreme vulnerability of patients with mental illnesses, this issue of the *AMA Journal of Ethics* critically investigates what it means to execute force in the most compassionate ways possible when, indeed, force is necessary. This issue brackets questions about when reasonable people disagree about the necessity of force and considers (1) the nature and scope of force's utility in practice when force is generally agreed upon as justifiable and clinically necessary, (2) models for reducing **iatrogenic trauma** from justifiable and clinically indicated force in health care, and (3) what might constitute compassionate implementation of **force protocols** when force is justifiable and clinically necessary. Exploring ethical questions about events that necessitate using force might well prove invaluable not only for recognizing weakness in current force protocols and guidelines but also for gleaning further insights into how our actions can express compassion, even when they must be forceful.

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Citation

AMA J Ethics. 2021;23(4):E289-291.

DOI

10.1001/amajethics.2021.289.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Execute Critical Force Interventions With Compassion, Not Just Harm Minimization, as a Clinical and Ethical Goal?

Robert L. Trestman, PhD, MD and Kishore Nagaraja, MD

Abstract

Responsibly determining whether and when to use potentially lifesaving force when caring for patients who are acutely mentally ill typically requires carefully applying 2 key ethical standards. First, short-term morbidity or mortality risk must be minimized. Second, potential long-term harm to a patient who is traumatized during a forcibly performed intervention and potential long-term consequences to a patient's trust in clinicians must be seriously considered. This article suggests these minimum standards in mental health care decision making are necessary but insufficient. It is proposed that clinicians' intentions and motivations should not be grounded merely in harm minimization; rather, they should be grounded in compassion maximization. The article then proposes criteria for what compassion maximization would look like in response to a case.

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Case

LL is a 25-year-old patient with a history of childhood trauma, self-injury, aggression, and schizophrenia who was involuntarily brought to the emergency department (ED). An ED physician found LL to be nonverbal but that LL could move their head slightly and confirmed LL's sudden development of rigidity and hypertension. Dr P, a consultant psychiatrist, then evaluated LL and confirmed that LL is posturing, notes that LL has stopped eating and drinking, and admits LL for malignant catatonia, a potentially fatal condition. A capacity assessment is conducted; LL is determined to lack capacity to make treatment decisions. LL's mother is then secured as LL's surrogate. LL is initially treated with oral benzodiazepines but then refuses them. Staff members agree that forcibly administering benzodiazepines to LL via intramuscular injection (IM) is both ethically justified and clinically necessary, given the threat posed by delaying treatment. LL's mother consents to use of IM benzodiazepines over the objection of LL. Nevertheless, surrogate consent staff are reluctant to proceed without LL's consent, noting that LL didn't come to the ED voluntarily and has refused medications during

hospitalization. Dr P continues to insist that medication against LL's will is appropriate, and this view is corroborated by 2 additional psychiatrist colleagues. "The longer we wait, the more LL suffers, and the more LL's life is at risk," Dr P explains.

Commentary

The ethics of forced treatment in psychiatry has long been a point of passionate dialogue in the field.¹ In psychiatry and in society, we tend to value **personal autonomy**, in contrast to the paternalism of mid-20th century practice. Psychiatry now also considers tensions between short-term pragmatism (ie, addressing an immediate crisis) and long-term illness management and recovery.

In psychiatry, forced treatment should generally align with a patient's values in order to neither exacerbate existing trauma nor alienate a patient from future treatment engagement.² Force can have significant and lasting negative impact on a patient's treatment experience and, as McLaughlin et al note, can be considered "toxic" in its impact on patient attitudes towards treatment."² Consideration of a patient's background and culture can inform decisions about whether to use force and how to execute it and to minimize harm. As reported in one significant study, showing "respect for you, your family, and those important to you"—ie, cultural sensitivity—was found to be the most important feature of compassion expressed by both patients and physicians.³ Understanding a patient's culture and history and demonstrating sensitivity are key to exercising force compassionately in psychiatry. This article argues for compassion maximization when force is necessary (ie, in some cases of psychosis or catatonia, in which individuals retain some conscious control, or in cases of acute delirium or intoxication).

Cultural and Social Context

Cultural context. Culture is a broad, encompassing construct. Multiple aspects of culture are relevant to the discussion of compassionate use of force, such as demographic characteristics and social development. Of relevance here, demographic variables primarily include race, age, gender, and socioeconomic status. Each variable contributes to a patient's decision-making processes, including decisions regarding forced care. For example, patients' race and gender provide a potential starting point for understanding their current behavior, including their reaction to psychiatrists as authority figures. Patients' socioeconomic status can similarly provide information about their formative experiences growing up in relative poverty or affluence. If patients have lived and continue to live in poverty, their prior experience of medical care might have been limited, inadequate, or dismissive, and they might therefore distrust physicians and medical staff. In gaining a more nuanced understanding of the context of a patient's life, we can not only convey a sense of compassion for the patient's current situation but also build a framework for understanding the patient's perspective. Patients' experiences might contribute significantly to how they advocate for themselves in the context of forced care. Integrating **understanding of patients' cultural context** into care delivery can guide communication and decision making and potentially reduce or eliminate objections to treatment. Trying to engage a patient in decision sharing is a key feature of compassion.

Social context. Social development includes relationship-building and understanding social expectations, which can heavily influence patients' attitude toward treatment. A patient from a community that stigmatizes mental illness as a character flaw or weakness or that devalues psychiatric care might have limited acceptance or

understanding of a diagnosis and needed treatments, which could lead to **crisis-driven forced treatment**. By adding information about patients' social background to case notes, we can more compassionately engage and support patients through their care journey. Specifically, we can help support patients' autonomy by making decisions informed by their values. When a surrogate decision maker is involved, as is often the case, effectively engaging that surrogate is key to compassionate implementation of force.

Compassionate Use of Force

Harm reduction or minimization is commonly a primary factor in the decision to treat against a patient's will. Involuntary medication, seclusion, or restraint is typically used with the intention of reducing risk of harm to an individual patient or others.⁴ While pragmatic and typically justified on those grounds, this determination is typically based on the clinician's value system and medical training ("first, do no harm"). Compassionate implementation of force, however, requires accounting for a patient's anticipated ideal outcome, not merely expected outcomes.

Compassionate care also includes enhancing patient autonomy and resilience. Given the chronic nature of many serious mental illnesses, patients can decompensate, which can compromise their decision making. In these situations, the focus should be not exclusively on lifesaving treatment but on supporting a patient's recovery as well. One such example is keeping an involuntarily hospitalized patient with mania safe by adjusting pharmacological treatment and engaging the patient in treatment. Physicians can use force compassionately in noncrisis situations to mitigate symptoms and work towards improving patients' decision making and ability to exercise their autonomy. A recovery model of mental illness emphasizes not "just treating or managing symptoms but focus[ing] on building resilience of people with mental illness and supporting those in emotional distress."⁵ When patients' decisional capacity is restored, patients can more clearly assess options and envision a future that might have been opaque during a crisis. A recovery model approach to compassionate use of force can help patients make their own **informed decisions** and introduce hope.

Harm Minimization in Compassionate Uses of Force

In LL's case, compassionate care would mean Dr P taking time to speak to LL's mother and trying to understand any childhood trauma and the origins and history of LL's self-injurious behavior. Such understanding might help the team reach consensus on a treatment approach after discussing the risk of harm and each of the potential therapeutic options as well as preserve the patient's sense of autonomy. When LL improves, this process—documented in the health record—would provide background for the team's decision; LL would be assured that their own desires and well-being had been considered. In fact, the compassion practiced by a patient's care team has been shown to be critical for "patient satisfaction and perceived quality of care."⁶ It is particularly important to minimize retraumatization risk or psychological damage, including feelings of humiliation and distress.²

In a more limited harm minimization approach, the treatment team would make the decision to use force, ignore the consent staff's appeals, and simply have the patient's surrogate sign the consent to treatment. In LL's case, whether the compassionate care or harm minimization approach is taken, the outcome of treatment might be the same in the short-term. Compassionate care, however, will likely lead to better patient outcomes in the long run due to lower risk of retraumatization, greater trust in caregivers,

improved patient autonomy, and higher likelihood of adherence to subsequent outpatient treatment. In particular, compassion improves “adherence to treatment recommendations,”³ and effective communication—a key tenant of compassionate care—is associated with “a greater therapeutic alliance” between clinician and patient.⁷

Compassionate caring means understanding each stakeholder’s roles. A patient’s physician acts as a decision coordinator (not as a key decision maker) and clinical mentor, synthesizing that patient’s cultural data and linking clinical and contextual facts to offer recommendations. As explored in LL’s case, the key decision maker is LL’s proxy, who has legal responsibility for decisions and can help clinicians better understand relevant facets of LL’s cultural background. A physician should seek to gather as much information from as many sources (ie, family, inpatient facilities, outpatient providers) as possible, as long as it does not hinder a proxy’s decision-making ability. In the case example, prior to any use of force in the treatment process, LL’s mother and the treatment team should exchange information regarding LL’s clinical history and social upbringing to truly understand whether injected benzodiazepine treatment is the best option for LL. This discussion builds upon a compassionate care framework and continues the work of establishing trusting relationships at each stage.

The final stakeholders in a patient’s care team are ancillary team members who administer therapies and acquire consent. A physician’s responsibility is to ensure that these team members understand a patient’s cultural context and how it informs treatment. For example, in the case of LL, Dr P should discuss with ancillary team members that information about LL’s cultural background and values was gained from available sources and discussions with a proxy and that a thorough review of likely harms and benefits of each potential intervention (including no intervention) was undertaken. In this way, all team members are made aware that the use of force is necessary and should be done with compassionate intention. This process can also help address team members’ concerns about implementing force in the course of LL’s care.

It must be acknowledged that compassionate care takes time to implement. Modern inpatient caregivers are under pressure to treat patients and discharge them quickly. Despite these system-based challenges, when necessary force is implemented with compassion, benefits to both the patient and the care team far outweigh the relatively modest time commitment.

Conclusion

Compassionate care integrates empathy with data-driven decision making and can bring together the patient and all members of a care team in support of a patient-centered care plan. Psychiatrists should consider compassionate use of force as standard of care when force is required, since it should be done with the aim not only of minimizing harm but also improving patient engagement and recovery. Psychiatrists might face lower barriers to engaging in compassionate care than some other specialists due to their relatively greater aptitude for empathy and higher level of interpersonal management training.⁸ Compassion benefits not only patients but also psychiatrists, as it leads to greater work satisfaction.² As physicians, we should strive to understand patients’ perspective and cultural context. When we do so, we are not only more likely to mitigate patients’ risk of harm but also to help patients engage and recover.

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Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2021;23(4):E292-297.

DOI

10.1001/amajethics.2021.292.

Acknowledgements

The authors wish to thank Mark Swope, PhD, director of medical ethics, Carilion Clinic, for his thoughtful review of this article.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Compassion Be Expressed as a Primary Clinical and Ethical Value in Anorexia Nervosa Intervention?

Melissa Lavoie, MD and Angela S. Guarda, MD

Abstract

Use of force in the care of patients with severe anorexia nervosa is controversial but can be justified when the disorder becomes life-threatening. This commentary examines the role of force in compassionate care of an adolescent patient hospitalized with extreme anorexia nervosa and suggests strategies for reaching consensus, minimizing harm, and maximizing the chance of a therapeutic outcome when forced intervention is a compassionate thing to do.

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Case

VV is a 17-year-old who has been hospitalized 5 times in the past year due to severe anorexia nervosa. Each admission was preceded by several weeks of dietary restriction, including fasting behavior, with VV often consuming as little as 200 calories per day. VV is admitted to the pediatric unit for medical stabilization and has refused to eat in the hospital over the past few days. She says she is hunger striking to protest how she was treated during prior hospitalizations and would eat if at home with her family. Her body mass index is 13 and her appearance cachectic.

VV's parents are desperate to convince VV to eat. Their worries grow as VV becomes weaker and develops electrolyte abnormalities, worsening bradycardia, and hypotension. VV's parents and clinical team recognize that VV's life is at risk and that chemical force, physical force, or both may be needed to treat VV. VV's physician recommends nasogastric tube placement due to her continued food refusal in order to initiate the refeeding process and to stabilize her medically. However, VV is refusing this intervention. VV's refusal—combined with her history of agitation, self-injury, and aggression—make placement of the tube and enteral feedings challenging. VV's parents have asked that tube feeding be implemented as soon as possible; however, they also request that VV be “put to sleep” rather than physically restrained for tube placement.

Despite agreement that forced tube feeding is necessary in the short-term to save VV's life, VV's mother and one of VV's nurses, GG, disagree about whether doing so is compassionate and respectful of VV's right to self-determination. During a team meeting with VV's parents, VV's mother says, "VV is a teenager. We're her parents, and it's our decision. VV has been and still is too ill to consent or even assent."

GG responds, "I see your point, but you have to consider long-term consequences for VV, too, and what it's like for us to have to force-feed her. The World Medical Association considers force feeding a human rights violation,¹ possibly even torture. I don't see that as a compassionate thing to keep doing to VV."

VV's mother adds, "Compassion is important, obviously. VV is our child. It is not, however, the primary value when compared to saving VV's life."

Everyone at the team meeting wonders how to respond and proceed.

Commentary

Anorexia nervosa is characterized by morbid eating restraint despite escalating negative consequences of starvation and has one of the highest mortality rates among psychiatric conditions.² Ambivalence towards interventions aimed at weight restoration is a hallmark of the disorder and contributes to high levels of perceived coercion in hospitalized patients, as most enter care under pressure from others.³ Forced clinical interventions are ethically and clinically justified only when a patient's decision-making capacity regarding appropriate treatment is impaired, when the risk of death or serious morbidity is high, and when the likelihood of benefit outweighs the risk of harm.

VV's treatment refusal despite her medical instability presents her clinical team with a conflict between the ethical principles of **respect for a patient's autonomy** and beneficence. In this commentary, we explore clinical and ethical justifications for the use of force in the treatment of anorexia nervosa. We discuss the limitations and risks of nasogastric tube feeding compared to other effective, less coercive behavioral treatments for anorexia nervosa and suggest strategies for a coordinated team-based approach that may include the compassionate use of force while prioritizing the establishment of a collaborative therapeutic relationship among VV, her family, and her treatment team.

Autonomy and Right to Self-Determination in Anorexia Nervosa

VV insists that she is on a hunger strike to protest prior perceived medical maltreatment while her nurse worries that force-feeding VV represents a **human rights violation**. Unlike a hunger striker, whose refusal to eat is based on a political goal that, once achieved, would render continued food refusal unnecessary, VV has readily relapsed following multiple past admissions and is unlikely to eat at home. Her decision-making ability is impaired in that she lacks the capacity to appreciate both the severity of her condition and her likelihood of benefit from treatment.⁴ It is not uncommon for patients with anorexia nervosa to recognize the need for others with the same condition to be treated against their will but not their own,⁵ and many involuntarily hospitalized patients retrospectively acknowledge that they needed hospitalization but were unable to make a reasoned choice to enter treatment while acutely ill and malnourished.^{6,7,8} Recovery from anorexia nervosa is often a protracted process that can take years; however, the majority of those affected will recover, with recovery possible even in the most severe and chronic cases.⁹ While ill, however, individuals with anorexia nervosa may express a

sense of hopelessness, and it is important that clinicians not accept as fact patients' statements about the futility of treatment.

Different Views About Necessity of Force

VV's medical team believes that some kind of force (physical or chemical) is necessary to save VV's life, although they differ on the form this intervention should take. VV is refusing meals and is medically unstable as a result of her state of severe malnutrition. To be successful, any coercive intervention must help reverse her starved state, restore her decision-making capacity, minimize harm, be as compassionate as possible, and be likely to benefit her in the long-term.

VV's mother wants the team to place a nasogastric tube under general anesthesia, presumably believing this will be less traumatic for VV than placement during a physical hold, with or without medication. Aside from the risk of anesthesia, waking up with a tube in place may be more traumatic for VV than having the tube placed while awake, and if VV removes her tube, she may require multiple reinsertions. A Danish register-based study identified repeat nasogastric tube insertion as common in involuntary hospitalizations for anorexia nervosa.¹⁰ Multiple reinsertions could increase risk for psychological and physical trauma, especially if VV actively resists them. Potential physical complications include nasopharyngeal trauma, tube misplacement, aspiration pneumonia, or esophageal perforation. Prolonged nasogastric tube feeding could decrease motivation to eat by mouth, result in tube dependency, and fail to assist VV in overcoming her fear of food.¹¹ VV's objection is not primarily to the mode of feeding (oral or nasogastric) but to feeding itself, which is not solved by tube placement under anesthesia, and VV may tamper with her tube feeds to avoid gaining weight.

Establishing Therapeutic Alliance

Clarifying VV's history. VV's case leaves us with unanswered questions regarding her treatment history. Although she has been hospitalized multiple times, many patients with anorexia nervosa obtain care in general medical or psychiatric wards where staff have minimal if any specialized training in eating disorders. Weight restoration is the strongest predictor of recovery from anorexia nervosa. Previously, on these other admissions, was VV's weight restored by discharge or was she just briefly medically stabilized and sent home? What follow-up care, if any, did she receive? The absence of a detailed treatment history has the potential to increase the risk that clinicians will opt for highly coercive interventions like involuntary nasogastric tube insertion, incorrectly assuming that the patient will be unresponsive to less invasive treatment approaches.

Building rapport. Compassionate and **empathic listening**, questioning, and reflection as part of history taking are important to establishing rapport with VV, as patients' perceived coercion concerning treatment has been linked to their feeling that they are not heard.¹² Collateral history collected from VV's parents and from review of outside records, where available, can help clarify the adequacy and quality of her prior hospitalizations and follow-up treatment. This information is crucial to helping the clinical team build a therapeutic alliance with VV, to instilling hope that she can get better, and to persuading her that the team is here to help her overcome her illness. A strong therapeutic alliance in patients with anorexia nervosa has been found to predict treatment completion and change in eating-related psychopathology, both at discharge and at 1-year follow-up.^{13,14,15}

Evaluating Options

Ideally, the team should consider urgent transfer to a specialty behavioral program for the care of patients with eating disorders, especially if VV has not been treated in one before or has left treatment prematurely on past admissions. Expert eating disorders behavioral specialty programs can improve eating disorder symptomatology and weight-restore a majority of patients using a multidisciplinary approach that includes individual, group, and family-based treatments; supervised meals; and behavioral contingency management strategies.¹⁶ When access to such a program is not possible or cannot be accomplished promptly, the team is faced with either winning VV's cooperation so that she starts eating meals or initiating tube feeding with the goal of transitioning VV to oral feeding as soon as possible. Signs that a patient might require urgent treatment to prevent life-threatening medical complications of malnutrition include a body mass index of less than 13, prolonged QT interval on electrocardiogram, severe hypoglycemia, or electrolyte abnormalities, especially hypokalemia or hypophosphatemia.¹⁷ For patients who meet these criteria, at least in the short-term, forced nasogastric tube feeding might be lifesaving. In most cases, there is need for urgent rather than emergent intervention, and, in these cases, an ethics consult could help resolve disagreements among team members and help them reason through available options.

Unified Team-Based Approach

Achieving a shared understanding of the psychopathology of anorexia nervosa and the unique challenges of treatment resistance posed by this disorder is a priority for the clinical team. Discussion and education concerning the clinical, ethical, and legal rationale for involuntary treatment, including possible recourse to nasogastric tube feeds, should ideally take place before meeting with family members to facilitate clear and consistent messaging to VV and her family and to avoid the overt **disagreement** observed here within the clinical team in the family's presence.

Cases like VV's can generate strong emotional reactions in staff, trainees, and family members, which may undermine the therapeutic relationship. These reactions can include a sense of urgency to intervene to save VV's life at any cost, feelings of futility about her potential for recovery, frustration at her refusal to cooperate with medical recommendations, or overidentification with anorectic rationalizations for her treatment refusal. The treatment team should recognize and explore these responses to ensure that treatment decisions are rooted in the guiding values of compassion and good clinical care and not in these disparate emotions. Acknowledging these emotional experiences as common can help de-escalate conflict and reassure staff. Parents are often distressed and exhausted by repeated attempts to help their child combat her illness and are also likely to benefit from support and education. It might be preferable to meet separately with VV and with her parents to discuss treatment options and to answer their questions.

Preparing the Patient for What to Expect

If the patient's worsening medical status places her at imminent risk and the decision is taken to proceed with nasogastric tube feeding, it is important to prepare VV for the procedure. She should be reassured that the team will be as gentle as possible, that the expectation is that the tube feeding will only be temporary, and that the tube will be removed once she is taking in sufficient calories by mouth. Both the medical rationale for enteral feeding and the team's goal to help her overcome her illness and gain control over healthy eating should be stressed. Calmly presenting VV with the plan and explaining the steps involved in inserting the tube, who will be present, the importance

of her cooperating, and the possible need for a brief physical hold will help VV know what to expect. This message should be delivered empathically yet clearly, stressing the urgency of helping her body obtain the nourishment it needs. Providing her a choice to eat a meal at the last minute by having a tray ready as an alternative to tube placement often avoids the need for enteral feeds, as some patients report it is easier to eat when they feel they no longer have the option to postpone doing so.⁵

Compassion as a Primary Value

While nasogastric tube feeding may be ethically justified when a patient lacks capacity to make treatment decisions and faces life-threatening medical consequences, it is important to consider alternatives to enteral feeding that minimize the use of force or implement it in a more compassionate way. Successful treatment of anorexia nervosa hinges on persuading patients to gain weight and consume calorie-dense foods despite their aversion to doing so. Meal-based oral refeeding is safer and always preferable to enteral feeds. Specialized behavioral programs for eating disorders can weight-restore the vast majority of patients without the need for nasogastric feeding by utilizing behavioral expectations and contingencies to enhance patient motivation, compliance, and autonomy.¹⁸ Access to these programs is limited, however, and few will accept involuntary adult patients. If VV's medical status or other limitations preclude her transfer to such a setting, short-term nasogastric tube feeding may be required to medically stabilize VV and initiate the refeeding process.

Compassion should always be a guiding value in the treatment of anorexia nervosa. In some cases of severe and life-threatening anorexia nervosa, however, compulsory treatment may be the compassionate choice, as patients' **impaired capacity to freely choose recovery over illness** can undermine their autonomy. Nonetheless, compulsory treatment should be undertaken with care and only when benefit is likely in order to minimize both futile interventions and risk of trauma. This decision requires careful assessment of the patient's past history and treatment outcomes, a unified team approach, a positive and caring therapeutic alliance, and dynamic reassessment of therapeutic progress.

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Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2021;23(4):E298-304.

DOI

10.1001/amajethics.2021.298.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE AND COMMENTARY

Should One Kind of Freedom Be Restricted to Promote Another?

Katherine J. Feder, MS, Janice I. Firn, PhD, LMSW, and Ryan Stork, MD

Abstract

Due to restraints' consequences for personal liberty and dignity, the threshold to apply restraints is understandably high and heavily regulated. However, there can be clinical scenarios in which restraint use can facilitate a patient's freedom. This article considers such a case and examines conditions under which using restraints offers therapeutic benefit for patients with traumatic brain injuries.

Case

Albert is a 33-year-old man who was recently the unrestrained driver in a motor vehicle accident. He was found unresponsive by emergency medical services with a Glasgow Coma Scale of 4, which indicates minimal response to defined stimuli. He was intubated and brought to the nearest hospital, where his workup revealed traumatic brain injury (TBI) consistent with severe diffuse axonal injury. Like many patients who suffer from TBI, Albert began to progress through the typical stages of recovery consistent with the Rancho Los Amigos Levels of Cognitive Functioning, a clinical tool used to describe the behaviors and cognitive deficits of patients who have experienced TBI.¹ It is a 10-level scale wherein level I indicates no response (coma) with total assistance required and level X indicates purposeful and appropriate response with modified independence (ie, able to function independently with compensatory devices or cognitive strategies), with a spectrum of progression in-between.¹ After 2 weeks in the intensive care unit, Albert stabilized and was transferred to a small inpatient rehabilitation unit for rehabilitation of his cognitive deficits, poor coordination, and right-sided hemiparesis.

During this time, Albert became agitated, restless, hyperactive, confused, and engaged in nonpurposeful behavior, consistent with level IV of the Rancho scale.¹ The care team discussed activities on the unit that would allow Albert to channel his restlessness, thereby aiding his recovery. Permitting Albert to engage in activities outside of his room would provide an outlet for his restlessness and theoretically prevent an escalation of his agitation due to his lying in bed for long periods of time. However, given his disorientation (ie, his inability to remember that he cannot ambulate safely without assistance), increased fall risk due to poor balance and right-sided hemiparesis, and motor restlessness, he would require the use of a lap-belt and wheelchair to minimize potential harms to himself when moving around outside of his room. The staff felt

uncomfortable using any type of restraint for an indication other than that with which they were familiar due to the scrutiny applied to restraint use. They wondered how to balance Albert's rehabilitation goals and safety needs within the existing regulatory framework.

Commentary

All individuals have a fundamental right to control their own bodies. **Use of physical restraints** is controversial, as restraints inhibit physical movement. The use of restraints is a reactive measure, permitted only in the absence of any effective alternative to protect patients from harming themselves or others. Restraint use in health care settings is governed by federal law,² state law, and the Joint Commission³ and is influenced by hospital policy, American Medical Association guidelines,⁴ and the Centers for Medicare and Medicaid Services.⁵ These regulations specify that the least restrictive effective restraint is to be used for the least amount of time and that its use to restrain a particular patient must be regularly evaluated.² In order to receive federal funding through Medicare and Medicaid, hospitals must comply with these guidelines and laws.⁵ Any locally developed policies must consider both national and state codes.

Although these regulations apply the same evaluation to all restraints, in effect there is a range of restraint modalities that limit liberty to varying degrees and that might have alternate uses in the clinical space. Here, we consider how a one-size-fits-all approach can be a disservice to patients and to caregivers when trying to optimize treatment of specific clinical conditions. Specifically, patients with TBI have predictable progressions over the course of recovery. Although progression through all 10 levels of the Rancho scale is variable and patient specific, each level is marked by clear characteristics that are readily assessed via physical and neurological exam by trained clinicians. Many patients with TBI progress through level IV, which is characterized by confusion and agitation; patients who make it to this stage will likely progress through it, but the length of time spent at each level will vary depending on the severity of the injury. It is not unusual for a patient with TBI to spend 1 to 2 weeks in a state of confusion and agitation, the treatment of which includes having outlets for restless energy. To provide these outlets safely, many rehabilitation hospitals with specialized TBI rehabilitation programs employ the use of lap-belts, enabling patients with TBI at level IV of the Rancho scale to leave their rooms and engage in group or physical activities in a manner that reduces fall risk. While this topic is empirically underexplored and relies heavily on expert opinion, in the experience of the third author (R.S.), which is consistent with the literature, these patients have shorter length of stay, greater likelihood of discharge to less restrictive environments, and improved clinical outcomes.^{6,7,8} This commentary considers ways in which restraints can be viewed as tools to support interdisciplinary best practices for patients with certain clinical conditions like Albert's, what factors can make clinical benefits of restraints outweigh their harms, and how restraints can be effectively and ethically regulated and applied.

Context-Specific Reframing of How We Use Restraints

When approaching any given medical intervention, health care professionals weigh the risks and benefits of that intervention and the likelihood of it achieving the intended outcome in relation to their patient's condition. Rather than continuing to view all restraints as restrictive and reactive measures to restrain and limit patient movement, we suggest thinking more holistically about how certain types of restraint may facilitate greater physical freedom in some ways while limiting it in others. The Joint Commission already recognizes how a clinician's intended use of equipment, such as bed rails,

affects whether it is considered as a restraint. Specifically, the *Accreditation Manual for Hospitals* states: “if the intent of raising the side rails is to prevent a patient from voluntarily getting out of bed or attempting to exit the bed, the side rails would be considered a restraint” but that “if the intent of raising the rails is to prevent the patient from inadvertently falling out of bed, then it is not considered a restraint.”³ We propose that lap-belts be evaluated over the range of their uses similarly to bed rails, based on their intended purpose as well as the patient’s best interests. Lap-belts would be used to prevent patients with TBI like Albert, who have progressed to level IV of the Rancho scale, from accidentally falling out of their wheelchairs or injuring themselves due to their disorientation and significant fall risk.

While the use of a lap-belt restricts patients’ freedom of movement by preventing them from getting up from their wheelchair and effectively restrains them in some ways, it facilitates patients’ freedom of movement by enabling them to safely navigate their environment and engage in activities to expel restless energy. Consider Albert’s scenario in which he is in a state of posttraumatic confusion (ie, unable to remember that he cannot get out of bed), restless, and has the potential for aggressive behavior. He does not have the ability to leave his room whenever he would like. His motor impairments are severe enough that staff (such as a bedside attendant) cannot safely ambulate the patient when he attempts to get out of his bed. This creates a scenario wherein Albert may be encouraged to stay in his bed, resulting in increased isolation and immobility, further escalating his restlessness. Utilizing a lap-belt, however, would allow him to leave his room when he would like with only near supervision of the patient attendant. He would be able to self-propel the wheelchair with his feet and explore his environment, effectively expanding his ability to interact with his surroundings as he so chooses. This can reasonably be seen as compassionate, so we suggest that a decision to use lap-belts based on balancing freedoms facilitated against freedoms curtailed is one that looks to motivate compassion.

Autonomy and Dignity

While some may argue that restraint use violates patient autonomy, patients suffering from symptoms of TBI are not acting with intention, nor do they possess meaningful understanding of their environment.^{9,10} While they may be able to express preferences through their actions, they do not have the ability to truly act autonomously or provide informed consent. As they do for other clinical interventions for patients who **lack decision-making capacity**, physicians should obtain informed consent from the patient’s surrogate decision maker. This process would include explaining why the lap-belt is recommended, the benefits and risks associated with its use, alternative options, and the scope of activity and duration for which it will be used.^{10,11,12}

The other critique of restraint use often falls into the category of dignitary harms—specifically, that the use of any restraint limits physical movement and therefore restricts a basic human right and liberty. However, when one weighs patients’ ability to leave their room and engage in activity while secured with a lap-belt against their remaining in bed, the latter can be seen as posing a greater harm by effectively environmentally restraining patients with TBI to their rooms all day, hindering recovery.¹² Thus, lap-belt use in specific contexts with the consent of the patient’s surrogate addresses suffering and promotes recovery, making it the more compassionate choice.

Regulation and Application

Like other medical interventions, lap-belt use would be limited to specific clinical indications in which it might confer benefit with authorization of the surrogate. It would be helpful to have a predefined set of criteria to help identify when using a lap-belt might be appropriate. A specialized clinician would evaluate whether the patient meets these criteria—and, if at any point the **risks outweigh the benefits**, the use of the lap-belt should be discontinued.

In rehabilitation hospitals, removal of restraints is typically a multidisciplinary decision based on observations from nurses, the therapy team, and neuropsychologists who are closely monitoring the patient's motor and cognitive recovery.^{13,14} Open communication among members of the interdisciplinary care team, access to advanced care clinicians, and correct application and positioning and frequent monitoring of lap-belts would be imperative to ensure that the lap-belts are used as intended, thus minimizing or preventing physical harms such as asphyxiation, increased agitation, or discomfort.¹⁵ If, at any point, the burden of the lap-belt outweighed its benefit, it could be discontinued. As patients with TBI would be engaging in activities that require supervision, such as moving around the hospital in a wheelchair or engaging in group activities, health care professionals would be readily available to identify if the lap-belt needs to be removed. Consistent with medication administration or services rendered, clinicians would document all use of the lap-belts.

Conclusion

By reframing lap-belts as a type of restraint that can facilitate freedom rather than purely restrict it for patients with TBI, we have an additional way to promote patient interests and well-being.

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Citation

AMA J Ethics. 2021;23(4):E305-310.

DOI

10.1001/amajethics.2021.305.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE AND COMMENTARY

Who Should Implement Force When It's Needed and How Should It Be Done Compassionately?

Matthew Lin, MD

Abstract

This case questions the comparative moral permissibility of 2 different uses of force—actions done against a patient's will—in the course of that patient's care: covert medication administration and use of physical or chemical restraint. The commentary considers what constitutes the most compassionate use of force for this patient and how it should be implemented.

Case

CC is a nurse in a skilled nursing facility caring for BB, a patient with a history of aggression, paranoia, emotional dysregulation, and schizophrenia. BB typically refuses medication when hospitalized for acute exacerbations of illness and is unable to self-care.

DD is BB's legal guardian and has authorized haloperidol to be orally administered to BB mixed into and hidden in BB's food. CC has administered oral haloperidol to BB this way but is increasingly uncomfortable doing so.

During an interdisciplinary team meeting, CC stated: "This kind of deception is generally viewed by everyone on the team as ethically questionable, probably since it is a kind of force, but I'm the only one who'll do it in order to avoid what's worse. If I don't, or if someone else doesn't hide the haloperidol in BB's food, BB gets an intramuscular (IM) injection, which is worse. When BB gets IM injections, administration of BB's meds gets delayed. We have to wait for multiple security guards to arrive on the unit to help restrain BB. It's loud, disruptive, distressing, and upsetting for everyone—BB, other patients, us—especially when it happens over and over again. If using force on this patient is going to be routine, we need to be executing it better. I mean, is there even a policy or a protocol about how we should be doing this? We need a plan that doesn't involve me being the only one relegated to doing the 'dirty work' of deception to spare BB the repeated physical trauma."

Members of the team wondered how to respond.

Commentary

Management of BB's symptoms in the setting of medication refusal presents a challenging question on the comparative moral permissibility of 2 ethically undesirable practices: covert medication and physical or chemical restraint (hereafter, restraint). Both can be understood as modes of force, or as actions used to overcome the will of the patient. This 3-part essay considers the most compassionate option for BB and how it can be implemented ethically. The first part reviews empirical research on covert medication and restraint in clinical practice and identifies principle-based ethical perspectives on the use of force. The second part balances the harms of both practices within a framework of compassion that draws on patient perspectives. The third part addresses the medical team's roles, responsibilities, and moral distress through a discussion of when and how force can be applied ethically.

Covert Medication and Restraint

Covert medication. Covert medication is the practice of administering medications to patients without their knowledge by concealing the medication in food or drink.¹ This practice might involve an overt lie or **deception through omission** on part of the caregiver. Although there is a paucity of empirical studies and practice guidelines on covert medication in North America, a small body of literature exists from Europe and South Asia. A 2010 review suggests that covert medication occurs in 43% to 71% of nursing homes in the United Kingdom, affecting 1.5% to 17% of residents.² In a 2002 study, 50% of families in India caring for relatives with schizophrenia reported using covert medication in the home setting.³ Practice guidelines that describe a narrow use for covert medication in patients lacking decision making capacity (DMC) have been published in England and Scotland.^{4,5,6,7}

Some ethicists argue that covert medication is never acceptable,^{8,9} while others have considered its usage in specific situations—for instance, with patients who lack DMC.^{10,11,12} A key ethical concern is the undermining of patient autonomy through deception, which is associated with several potential harms. Deception prevents patients from **gaining insight** into their illness and might lead to further medication refusal and an ongoing deception loop, and, if discovered by the patient or public, deception might damage the therapeutic relationship and trust in the medical profession more broadly.^{13,14} Additional harms of covert medication include potential decreased drug efficacy and increased adverse effects from dose form modification of medications, which deceived patients might not be able to recognize or articulate.^{12,15}

Restraint. Restraint is a form of coercion, or the intentional use of a credible and severe threat of harm to control another, which might involve physical holding or forced oral or intramuscular medication.¹⁶ In contrast to covert medication, restraint has been studied more rigorously. A systematic review of studies published between 1990 and 2010 estimates that 3.8% to 56% of patients admitted to psychiatric wards internationally experience some form of restraint.¹⁷ Efforts to reduce the use of coercive measures have been addressed in several professional guidelines internationally, and restraint is largely regarded by expert consensus as a last resort in the treatment of behavioral emergencies when patients pose an acute danger to themselves, medical staff, or other patients.^{18,19,20,21} Accordingly, less traumatic and restrictive alternatives are professionally preferred.^{22,23}

Restraint, like covert medication, violates patient autonomy. In weighing beneficence and nonmaleficence in the use of restraint, the primary benefit is the immediate

protection of the patient in an emergency situation at the cost of a process that is both physically and psychologically injurious.²⁴ Research evaluating the effectiveness of restraint relative to other coercive measures is limited by definitional heterogeneity, clinical practice variation, and ethical challenges in study design, and thus the benefits of restraint for patients remain unknown.^{25,26}

Force and Compassion

A virtue-based approach to what constitutes compassionate use of force can complement principle ethics, in that **compassion can be understood as a virtue** that includes cognitive, affective, and motivational components that allow for an awareness of the suffering of others and a desire to relieve it.^{27,28} Although there is no consensus definition of *suffering*, some ethicists have described it as a state that extends beyond physical pain to include mental, emotional, and spiritual elements.²⁹ In BB's case, a review of the multidimensional harms experienced by patients affected by force can provide insight into what the most compassionate option for BB might look like, assuming that BB lacks DMC.

Patient perspectives on the harm caused by restraint have been well described. In a systematic review of 26 studies, Tingleff et al thematically analyzed the reported experiences of psychiatric patients before, during, and after restraint and found that patients held deeply negative perceptions of coercion at all stages.³⁰ During coercion, themes of physical discomfort (ie, pain from injections or restraint) and the perception of being controlled, marked by feelings of mental abuse, humiliation, and disempowerment, featured prominently in patients' narratives. After coercion, patients cited as long-term effects feelings of fear, helplessness, trauma, and loss of trust in people.³⁰

If restraint is deemed the only acceptable option, it should be implemented with attention to the patients' stated needs to minimize suffering. For instance, during coercion, patients have stated the need for clinicians to be present, respectful, and communicative.³⁰ After coercion, patients have stated the need for debriefing with the medical team.³⁰ Trauma-informed models to guide this type of communication exist and have been shown to reduce future episodes of restraint and promote the postrestraint recovery process.^{31,32,33}

No studies known to this author have explicitly addressed patients' experiences with covert medication, although literature exists on patient preferences concerning emergency psychiatric care and deception. Sheline and Nelson found that when patients with psychiatric illness were given a hypothetical choice of restraint or antipsychotic medication in an emergency, 64% of surveyed patients preferred medication.³⁴ Based on patient responses from emergency services forums, Allen et al found that patients preferred oral medications and overwhelmingly rejected forced injections.³⁵ Qualitative research exploring the attitudes of patients with Alzheimer's to deceptive behaviors in dementia care (though not specifically covert medication) has shown that patient responses to hypothetical deception scenarios are complex and varied, with some patients feeling that deception is always unacceptable and others considering it to be permissible if it is in the patient's best interests.³⁶

A virtue-based perspective suggests that, given the significant physical and psychological suffering experienced and voiced by previously restrained patients, covert

medication might be the more compassionate option, with the caveat that more research is needed on patient experiences of covert medication.

Roles, Responsibilities, and Practice

Selecting covert medication over restraint as the more compassionate mode of force raises the question of how it can be implemented ethically. Several decision-making tools for clinicians in implementing covert medication have been described by ethicists.^{10,12,13,37} Recommended strategies include consistent reevaluation of patient DMC, **interdisciplinary team ownership** of the decision and practice, and weighing benefits of covert medication against its harms. Such strategies help to clarify the roles of team members responsible for implementing covert medication while also providing avenues to address team members' moral distress or ethical concerns.

Evaluating the presence or absence of DMC is a critical prerequisite to considering covert medication.^{10,12} Verification of DMC should include an evaluation of whether or not BB can understand the situation, appreciate the consequences of the decision and potential alternatives, and communicate a rationale for their decision.³⁸ If BB is deemed to have DMC and medication is still refused, then that wish should be honored by medical staff. If BB lacks DMC, weight could be given to BB's prior wishes expressed in past conversations about medication preferences and the use of coercion and deception or in psychiatric advance directives, if available. Alternatively, if such information is lacking, surrogate decision makers can present decisions based on what they believe are in BB's best interests.

If BB is found to lack DMC and covert medication is considered, all team members involved in BB's care must be involved in this initial discussion.^{10,39} This interdisciplinary discussion should include family members, nurses who administer the medications, physicians, pharmacists (to ensure dose modifications would be safe and effective), and input from an ethics committee. Although BB's legal guardian has authorized covert oral haloperidol, to address the medical staff's moral distress, the team should re-review this decision to better understand the reasoning and justification for it.

As part of the interdisciplinary discussion, agreement should be reached on whether a favorable benefit-to harm-ratio exists—that is, whether the benefits of covertly administering medication significantly outweigh the harms of violating the principles of respect for patient autonomy and nonmaleficence. Potential benefits of covert medication for BB might include preventing acute decompensations that result in restraint and treating BB's paranoia, aggression, and lack of self-care, which in and of itself may be a form of suffering and erode autonomy.³⁹

Conclusion

Covert medication and restraint are 2 ethically problematic practices from a principle-based perspective that are rooted in deception and coercion, respectively. Through the lens of virtue ethics, covert medication could be considered the more compassionate mode of force, given patients' descriptions of suffering from restraint. If involved team members decide that covert medication is indicated because of BB's lack of DMC, previously expressed wishes, or a surrogate decision maker's substituted judgment—and if there is a highly favorable harm-to-benefit ratio—this decision must be transparently discussed, documented, and reevaluated frequently with the entire care team.

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Editor's Note

This essay is the winning essay of the 2020 John Conley Ethics Essay Contest. The case to which this essay responds was developed by the editorial staff.

Citation

AMA J Ethics. 2021;23(4):E311-317.

DOI

10.1001/amajethics.2021.311.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

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

Christopher G. AhnAllen, PhD

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)¹; inpatient psychiatry (for behavior that is self-injurious or aggressive or threatening to others, physical assaults)²; critical care (for agitation, self-extubation, removal of arterial and venous lines, declining life-saving treatment)³; 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."⁴ 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)⁵ and 8.0% (Germany).^{2,6} In one Norwegian hospital, immigrants (21.6%) were more likely to be restrained than native persons (12.9%),⁷ 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.⁸ More recently, various interventions have been successful in reducing the rates of forced care procedures within health care environments.⁹ 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.¹⁰ 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.¹¹ 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.¹⁰ 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.¹² 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.^{13,14}

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.”¹⁵ 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.¹⁶ 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.¹⁷ 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.¹⁸

Promote compassionate care. A trainee's care of the patient is enhanced when a compassionate approach is emphasized.¹⁹ 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.²⁰ 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.^{21,22} 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.²³ 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.^{24,25} 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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Citation

AMA J Ethics. 2021;23(4):E318-325.

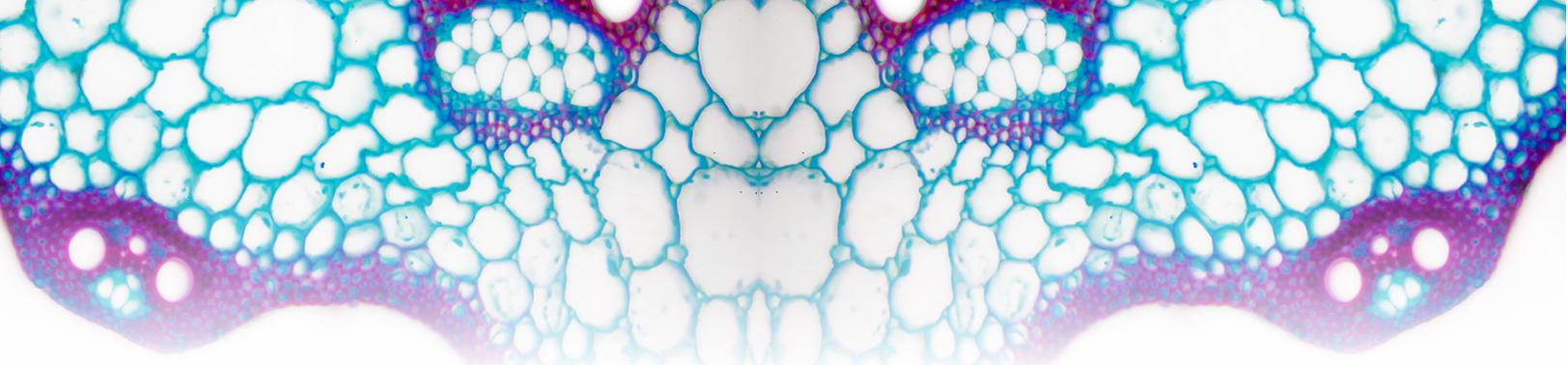
DOI

10.1001/amajethics.2021.318.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

April 2021, Volume 23, Number 4: E326-334

IN THE LITERATURE: PEER-REVIEWED ARTICLE

What Might a Good Compassionate Force Protocol Look Like?

Constance E. George, MD, MA

Abstract

This article focuses on uses of force in clinical settings after a triggering event—a behavioral or medical crisis—and considers how force should be implemented. The clinical stakes are high, as force can undermine therapeutic capacity in patient-clinician relationships, exacerbate moral distress, and erode trust. Yet they are rarely discussed. This article explores *compassionate* use of force rather than merely *minimally harmful* use of force and considers how and by whom force should be executed; the nature and scope of goals, motivations, and protocols that should guide caregivers who must implement force protocols; and what a good compassionate force protocol might look like.

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Patient Rights and Force

Compassionate use of force is not a combination of words destined to join the ranks of oxymorons, but rather a concept that can be implemented in practice and protocol development. Existing tenets pertaining to uses of force in health care are currently based on patient rights, which can be mandated and enforced via civil means (fines) or legal means (suits or charges). The Centers for Medicare and Medicaid Services (CMS) defines and sets standards for patient rights regarding force in hospitals (see Table 1).¹

Table 1. Centers for Medicare and Medicaid Services Definitions of Force and Standards for Its Use in Accord With Patient Rights

Definition
<ul style="list-style-type: none">• “<i>Seclusion</i> is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.”• A <i>restraint</i> is “any manual method, 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.”• A <i>drug</i> is considered a restraint “when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.”

Standards

- Seclusion or restraint “may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.”
- Every patient has “the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.”
- “Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others.”
- The patient must be evaluated within one hour as to the patient’s (a) “immediate situation,” (b) “reaction to the intervention,” (c) “medical and behavioral condition,” and (d) continued need for restraint or seclusion.
- Seclusion and restraint “must be discontinued at the earliest possible time.”

Adapted from Condition of participation: patient’s rights.¹

Patient rights are instrumental in expressing the ethical principles of respect for persons, patient autonomy, informed consent, just care, and other values that improve health care service delivery.² Compassionate care and a compassionate use of force, however, can be difficult to define and arguably even more difficult to codify or mandate.³ Chochinov presents a concise description of compassion that’s useful here:

Compassion refers to a deep awareness of the suffering of another coupled with the wish to relieve it. Compassion speaks to feelings that are evoked by contact with the patient and how those feelings shape our approach to care. Like empathy (identification with and understanding of another’s situation, feelings, and motives), compassion is something that is felt, beyond simply intellectual appreciation.⁴

Awareness of suffering and the motivation to relieve it, as described by Chochinov, are at the heart of **compassionate care**. Sinclair et al generated an empirically based clinical model of compassion that encompasses patient-defined virtues, including genuineness, love, honesty, openness, authenticity, understanding, tolerance, kindness, and acceptance.⁵ When expressed by clinicians’ demeanors, behaviors, attention, and treatment, these virtues promote patients’ experience of compassionate care.⁵ Compassion also requires that clinicians treat each other with compassion,⁶ as compassion is part of a caring climate. This cultural dimension of health care delivery is not lost on patients and is key to clinicians’ ability to apply force with compassion.

Compassionate Force

In general, force protocols are implemented when a **behavioral or medical crisis** presents an imminent threat of harm or actual harm to self or others. A crisis’ etiology can be psychiatric, substance induced, related to a medical condition, or iatrogenic. These etiologies can inform a patient’s course of treatment as caregivers pursue their common goals of becoming fully aware of patients’ symptoms of psychomotor agitation (see Table 2) and other signs of their experiences of suffering, which could trigger the need to use force to try to relieve that patient’s suffering.^{3,7}

Table 2. Symptoms of Psychomotor Agitation, Signs of Suffering

Type	Behaviors and Experiences
Verbal	<ul style="list-style-type: none">• Raised voice• Refusal to communicate• Aggressive language with evidence of anxiety, irritability, or hostility• Moaning

Behavioral	<ul style="list-style-type: none"> • Facial tension • Pacing • Rocking • Gesticulating • Clenched fists • Wandering • Pulling at medical tubes or interventions
Cognitive	<ul style="list-style-type: none"> • Delusions • Hallucinations • Disorientation
Physical	<ul style="list-style-type: none"> • Labile vital signs • Tremor • Fever • Tachypnea • Tachycardia • Diaphoresis • Difficulties with coordination

Adapted from Iroku-Malize T, Grissom M⁷; Ringer L⁸; Helman A.⁹

A consensus statement of the American Association for Emergency Psychiatry, Project BETA (Best Practices in Evaluation and Treatment of Agitation) De-escalation Workgroup in 2012 delineated first steps for managing a patient with agitation: ensure the safety of the patient, staff, and others; help the patient manage their emotions and distress; help the patient maintain or regain control of their behavior; and avoid coercive interactions that could escalate the patient's agitation.¹⁰

As in emergency departments, clinics, nursing homes, and other settings where agitated patients are commonly treated,^{7,9,11} de-escalation is widely regarded as key in crisis intervention.¹² Compassionate behaviors such as empathizing, listening, and inquiring can help de-escalate a crisis and inform intervention strategy. Learning to empathize with patients experiencing agitation from dementia, for example, inspires confidence¹³ and can change clinicians' linguistic descriptions of agitated patients—from *aggressive* and *disruptive*, for example, to *frightened*, *frustrated*, and *struggling with an unmet need*.¹³ When clinicians focus on learning more about a patient's experience and on fulfilling an agitated patient's unmet need in this way, force might not be needed.⁸ Inquiring about a patient's experiences with prior interventions can also help clinicians remain present with a patient in crisis, help a patient feel safe, and help build trust (see Table 3).

Table 3: De-escalation Techniques

Type	Examples
Verbal	<ul style="list-style-type: none"> • Be present and calm. • Empathize, listen, reflect, reassure. • Respect needs to communicate in different ways, such as language or cultural differences. • Let the patient suggest alternatives or choices.

Environmental	<ul style="list-style-type: none"> • Offer the patient unrestrained seclusion in their room or in a seclusion room with the door open. • Offer distractions, such as books, music, films, or puzzles. • Involve a health care professional with whom the patient might have a good relationship.
Pharmacologic	<ul style="list-style-type: none"> • Offer medications; ask which medications help the most and involve patient in the choice.
Safety	<ul style="list-style-type: none"> • Enlist enough staff. • Survey dangers. • Remove hazards. • Attend to other patients and personnel.

Adapted from Ringer L⁸; Registered Nurses' Association of Ontario¹¹; Kontio R, Välimäki M, Putkonen H, Kuosmanen L, Scott A, Joffe G.¹⁴

If or when de-escalation starts to fail and force is needed to maintain safety, it is important for clinicians to clearly inform the patient that they must regain control or the strategy for keeping everyone safe will change.¹⁵ If force is needed, the language used by clinicians becomes relevant again. For example, labeling an intervention *minimally harmful* suggests we don't really see that intervention as appropriate treatment, in terms of the likelihood of benefit to the patient outweighing the risk of harm. Forcibly using **antipsychotic medication** to treat a patient who is not safe or making others unsafe is a compassionate clinical decision; this medication should be administered forcibly, if needed to maintain safety, with the goal of ameliorating the patient's suffering and restoring the patient's own capacity to remain safe, not with the goal of chemically restraining the patient.¹⁶ Language transforms the clinician-speaker from a chemical restrainer (abrogator of freedom) to a giver of appropriate medication (reliever of suffering).¹⁶ When compassion is intentional, a force protocol is part of a relational approach to taking good care of a patient.

Project BETA Guidelines

The American Association of Emergency Psychiatry's Project BETA (Best practices in Evaluation and Treatment of Agitation) keeps compassion and relief of suffering at its center. If patients experiencing escalating agitation relay or demonstrate that they can refrain from physically harming themselves, open seclusion and observation can be implemented.¹⁷ In open seclusion, distractions (eg, reading materials, music, film, and puzzles) can be useful¹⁸ and are commonly used to manage agitation in patients with dementia⁸ or other patients demonstrating an inability to redirect themselves to relieve their own suffering. Clinicians who are aware of patients' inability to self-soothe can help by offering distractions and, if patients cannot refrain from harming themselves or others, restraining and involuntarily medicating them for their own and others' protection.¹⁷ The physical and psychological needs of patients must be attended to while they are restrained or secluded. A clinician must continually evaluate¹ restrained or secluded patients; this presence with the patient is integral to compassionate caregiving.⁵ A clinician must also enlist restrained or secluded patients in their own release as soon as possible¹; ongoing patient-clinician dialogue acknowledges and promotes relief of patients' suffering and begins the process of restoring patients' autonomous action.

The relational nature of compassionate care in situations that require force is exemplified by Tan et al's 2010 study,¹⁹ which examined attitudes of patients with

anorexia nervosa toward compulsory treatment and forced nutrition. All participants agreed that implementing force to save life was indicated and acceptable. Importantly, this evaluation of acceptability was based not on clinicians' obligation to try to save patients' lives when illness abrogated their capacity but on patients' perceptions of both compassionate care and clinicians' intentions to help them.¹⁹ In this way, the compassionate delivery of care helps patients cope with the necessary use of force.

Compassion Fatigue Undermining Compassion

Because compassion is relational and cultural, compassionate care does not start and end with patients but extends to clinical staff caring for patients. Compromised patients assaulting clinicians and staff occurs far too often. For nurses, this occurs most often in emergency departments, inpatient psychiatry units, and nursing homes,²⁰ and long-term effects of violence against nurses include their developing negative coping strategies and experiencing stress, anxiety, fear, guilt, self-blame, and burnout.²¹ Burnout among clinicians is related to *compassion fatigue*, which results from "prolonged, continuous and intense contact with patients, the use of self, and exposure to stress"²² and is a threat to nurturing compassionate intention. Compassion fatigue is characterized by exhaustion; anger and irritability; negative coping behaviors, including alcohol and drug use; reduced capacity for feeling sympathy and empathy; diminished sense of enjoyment or satisfaction with work; increased absenteeism; and impaired decision making.²³ Preserving clinicians' compassionate intentions and motivations during the application of force in the course of caring for patients depends on addressing burnout, mitigating compassion fatigue, and adequately staffing units with acutely ill patients experiencing agitation that's hard to manage while preserving safety.²⁴

Physicians are often removed from an actual use of force event, and this is another reason to foster a compassionate culture that values the labor of and expresses respect for those implementing force protocols. When physicians aren't part of force implementation, they have a responsibility to offer leadership in nurturing a compassionate culture of collegiality and patient care. After force is implemented in the care of a patient, a physician must assess the patient at the next available opportunity (a patient right per CMS) and should order indicated changes to the patient's care plan. A physician can also assess and care for colleagues involved in a force event.²⁵ Compassionate care decreases clinician burnout, which in turn improves patient outcomes.²⁶ For this reason, medical systems are working to implement compassionate care in the psychiatric field and as a core component in the delivery of medical care.^{3,6,11,13}

Compassionate Force Protocol

Even when justifiable, force can undermine therapeutic capacity in patient-clinician relationships and must be forthrightly acknowledged as inherently coercive. The patient rights codified by CMS are designed to prevent abuse and to guide harm reduction when force is needed to preserve or restore safety. Harm reduction, however, should not be regarded as sufficient in safeguarding patients who are restrained or secluded. In psychiatric settings, for example, patients who experienced force reported that their psychological distress was contributed to by lack of information, unmet basic needs, inadequate communication from caregivers, and absence of post-seclusion follow-up.^{18,27,28} They also reported feeling publicly humiliated, lonely, helpless, abandoned, and punished.¹⁸ One thing these findings should prompt us to ask is this: *From whose perspective is harm deemed "reduced" or sufficiently reduced, particularly if the goal is safety?*

Other patients, however, found seclusion helpful, as it afforded them an opportunity to collect themselves, reenergize, and heal; they felt protected as a result of being forced to refrain from performing actions they might later regret.¹⁸ Factors that mitigate patients' negative reactions to restraint and seclusion include clinicians sharing relevant information with patients, staff members' quick and efficient actions and calm presence, the delivery of comfort care, and patient enlistment in a release plan and post-event debriefing.²⁷ Post-event debriefing offers opportunities for patients to share their experiences of forced intervention and should be used to collaboratively inform subsequent care planning for patients.²⁷ The patients with **anorexia nervosa** in the Tan et al study, for example, reported that attentiveness and compassion from clinicians mitigated their negative experiences of forced intervention and opened the possibility of their seeing that the forced intervention was therapeutic.²⁹ These factors suggest that forced interventions need not merely aspire to a clinical and ethical minimum of harm reduction but can be implemented with compassion. A compassionate force protocol is presented in the Figure.

Figure. Protocol for Compassionate Implementation of Force in Health Care Settings

Step 1: Assessment of a Behavioral Crisis	
1.	What is the setting: emergency room, medical inpatient, psychiatric inpatient, nursing home?
2.	What is the etiology and presenting behaviors? Is the general problem known—psychiatric, substance induced, medical, iatrogenic?
Step 2: Pending Behavioral Crisis	
1.	De-escalate <ol style="list-style-type: none"> a. Verbal: stay calm, listen, empathize, provide comfort, gently persuade b. Environmental: offer open seclusion, redirect, walk with patient, provide distractions c. Pharmacologic: enlist the patient in an offer of medication appropriate to presentation d. Medical condition: address the underlying source and treat along with above interventions
2.	Safety <ol style="list-style-type: none"> a. Assess resources, have adequate staff at the ready to ensure quick and efficient care b. Remove possible hazards c. Address safety and urgent needs of other patients
3.	Stay aware of escalating behavior <ol style="list-style-type: none"> a. Changes in behavior: pacing, increasing hyperactivity b. Changes in demeanor: hostility, verbal or physical aggression c. Cognitive changes: hallucinations, delusions, altered mental status d. Changes in physical parameters: fever, tachycardia, tachypnea, sweating, tremor
4.	Inform <ol style="list-style-type: none"> a. Inform the patient of expected behavioral control b. Inform the patient that violence is unacceptable c. Propose a resolution d. Inform patient as to the possibility of restraint or seclusion
Step 3: Use of Force	

-
1. Is the patient with psychomotor agitation an imminent threat to self? No
 - a. Place in quiet seclusion, preferably open with 1:1 staff, offer medication, make repeated attempts to engage patient in safety plan
 - b. If patient will not sit in a quiet unlocked room, place in quiet locked seclusion room, medicate if indicated, monitor
 - c. Dementia: Employ de-escalation techniques: 1:1 staffing, reduce stimulation, may lay hands on to redirect or provide comfort, consider as-needed medications known to patient
 2. Is patient presently harming self or an imminent or actual threat to others? Yes
 - a. Restrain and medicate patient as indicated with respect to resources
 - b. In dementia, physical restraint only for short periods of time, 1:1 required, continue above techniques to redirect and explore the possibility of unmet need
 3. Provide compassionate care
 - a. Monitor patient, do not leave unattended
 - b. Keep patient informed of events, stay calm, use even tones
 - c. Provide comfort care, attend to patient needs, provide companionship
 - d. Engage patient in treatment plan and behaviors necessary to discontinue involuntary treatment; open dialogue when appropriate
 - e. Monitor the other patients for signs of distress and provide comfort care and direction as needed
 - f. Monitor the treatment team and associated staff for distress and provide comfort care
-

Step 4: Debrief

1. Debrief the patient and staff, consider treatment plan and adjust care, consider impact on staff, and adjust procedures or protocols as indicated
-

Conclusion

This article posits that force can and should be implemented compassionately. Compassion is an indicator of quality for patients⁵ and should be regarded as an indicator of good character and collegiality among clinicians. Explicitly integrating patient rights into compassionate care offers therapeutic possibility in cases in which force is needed to preserve or restore safety and offers clinicians intellectual room and space to perform and assess their actions as *healers* with skill and intention rather than as judges, safety monitors, or adherence enforcers. Compassionate care incorporates clinician presence, patient-clinician sharing and dialogue, reassurance, kindness, empathy, and attentiveness as factors that can mitigate patients' negative experiences of forced interventions and preserve therapeutic capacity in patient-clinician relationships.

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Citation

AMA J Ethics. 2021;23(4):E326-334.

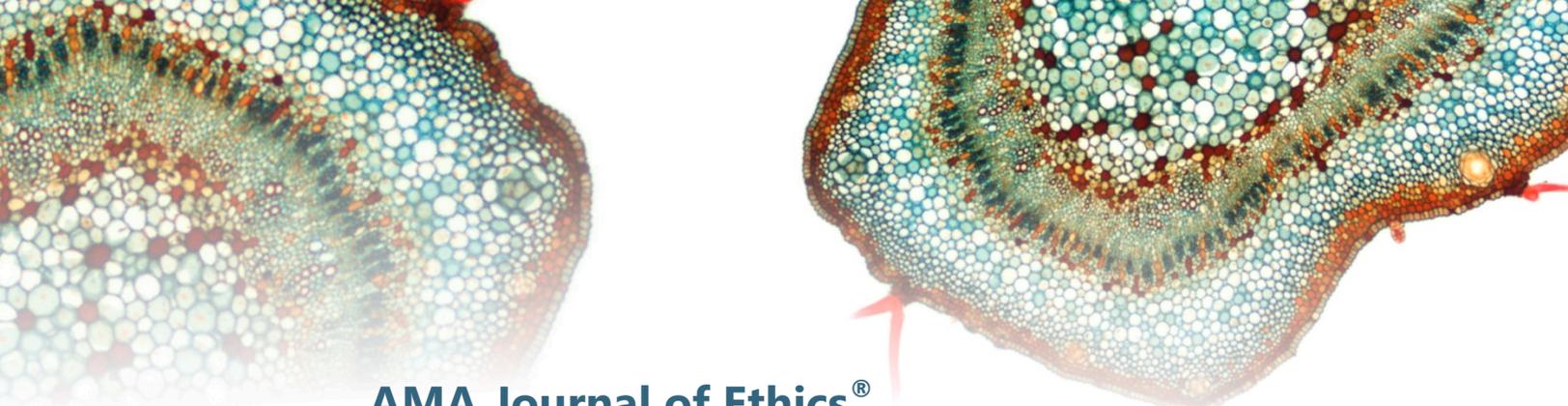
DOI

10.1001/amajethics.2021.326.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

April 2021, Volume 23, Number 4: E335-339

HEALTH LAW: PEER-REVIEWED ARTICLE

How Does Law Support Compassionate Mental Health Practice?

Ethan N. Sales, MD and Philip J. Candilis, MD

Abstract

Compassion has long been a bulwark of mental health law. Civil commitment, guardianship, mandated clinical intervention, diversion courts, involuntary medication, insanity defenses, and aid-in-sentencing evaluations are all elements of compassionate mental health practice. *Parens patriae* (the state as parent) and the least restrictive alternative are the specific concepts supporting therapeutic intention and purpose and are particularly relevant in cases in which force may be needed in the course of a patient's care. This article considers how using law compassionately can be evident even in forced clinical interventions.

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Therapeutic Jurisprudence

There has always been compassion in mental health law, especially when leverage is needed to protect patients from dangerous behavior or decisions. Civil commitment, for example, implies care in placing persons diagnosed with mental illness in hospitals, especially when they would otherwise refuse and be a risk to themselves or others. Civil commitment is an opportunity for people to **address symptoms of mental illness** in a more therapeutic environment than jail or prison. In placing people with mental illness in environments more likely to promote recovery, civil commitment can be seen as a compassionate exercise. Guardianship, too, assigns a trusted advisor or family member to assist in decision making for patients who are incompetent. These approaches are based in *therapeutic jurisprudence*, which utilizes legal proceedings for therapeutic ends.¹ Fundamentally, the principle explores the therapeutic implications of the legal process.

Compassionate Thinking in Law and Medicine

At the 2019 annual meeting of the American Academy of Psychiatry and the Law, forensic psychiatrists who had contributed significantly to the evolution of compassionate thinking in law and medicine presented their work at a workshop.² In seminal writings for the profession decades earlier, discussant Ezra Griffith of Yale University had advocated for a cultural formulation of assessments conducted for the

courts that accounted for the experience of people of color.³ His clarion call has become prescient in light of deaths in custody like those of George Floyd, raising questions about the true protections of constitutional rights.⁴ For a large swath of the profession, Griffith can be said to have triggered a reexamination of compassion when physicians conduct civil and criminal work. Joined over the years by some of his colleagues on the panel that day, Griffith explored narrative ethics, especially storytelling as a way to evaluate the experiences and behaviors of those caught in an unsympathetic judicial system. Narrative ethics was a pioneering attempt across disciplines to bring to bear humanistic values in fields such as medicine,⁵ as well as in philosophy, history, economics, and law. With the realities of uneven treatment of disadvantaged persons clear to both the clinical and the forensic professions, professional legal ethics had to speak directly to the **structural injustices** that resulted in the greater arrest, arraignment, prosecution, and punishment of persons of color. Indeed, the social determinants of health and health disparities themselves were already recognized.⁶

Panelist Michael Norko argued that compassion had to find its way into forensic and legal practice if the human experience was to count for anything in psychological evaluations for the courts.⁷ Norko holds that compassion gives professionals an “approach to justice that allows us to attend to and engage the humanity of all the subjects of our evaluations.”⁷ Through compassion, professionals are able to recognize and respect humanity in all persons with whom they engage, no matter their background. This compassion is essential because, without it, police and judges, just like forensic experts, simply perpetuate existing inequities.

Supported by writings of the American Medical Association (AMA) on vulnerable people and values,⁸ 2 other panelists, the second author (P.J.C.) and Richard Martinez, built on the AMA’s view of professionalism as something structurally stabilizing and morally protective. An antiseptic or technical exercise of law was not enough to ensure justice for participants in legal processes. Justice had to be informed by a person’s specific circumstances and the social determinants of their court involvement. Otherwise, courts, community, and participants were deprived of nuance and context. Procedures alone removed the humanity and social meaning from the legal interaction—an interaction that required empathy and compassion to capture history and social context.⁹

Compassion and Dignity

The compassion Norko finds at the heart of ethical forensic practice may be linked to a fundamental precept in modern philosophy: dignity. Dignity of the person is specifically identified by Alec Buchanan as the aspect of personhood most deserving of unconditional respect.¹⁰ American jurisprudence, for example, provides certain fundamental protections to those in its control: access to an attorney, the presumption of innocence, a jury of one’s peers. Echoing the writing of philosophers from Thomas Aquinas to Immanuel Kant, Buchanan is among those who recognize an inherent worth to human existence. Whether endowed by the Creator or by humanity itself, dignity exists by virtue of one’s capacity to be moral, to make decisions, and even to aspire to an ideal.¹⁰ Dignity thus goes beyond the law’s inherent respect for one’s autonomy or self-rule.

Modern conceptions of dignity demonstrate its **close connection to compassion**. With its etymological roots in the Greco-Roman *dignitas*, dignity has been loosely translated as the state or quality of earning respect, honor, or self-esteem.¹¹ Social rank played a

large role in its classical meaning, while Griffith describes it as more akin to “wisdom, rank, and position,” as well as “essential and inviolable humanity.”² Utilizing this more modern working definition, compassion for people caught in the legal system may be seen in many of society’s efforts to find dignity among those accused of transgressions against it.

***Parens Patriae* and Least Restrictive Alternatives**

The ethos of compassion in involuntary treatment is traditionally justified by the doctrine of *parens patriae*, the state as parent. Although the state is not always the disciplinarian, it is the resolver of disputes, the de-escalator, the keeper of the peace. The doctrine is often applied in cases of juveniles or adults with disabilities that affect their executive functioning.¹² Within *parens patriae*, the *least restrictive alternative* limits the law’s parental controls. Landmark legal cases^{13,14} ensure involuntary patients the maximum level of freedom while their illness continues to be treated safely.

Involuntary treatment as an extension of parens patriae. Applying legal oversight and the least restrictive alternative to involuntary treatment can help allay some of the fears that patients experience in receiving such care. An argument for treating patients without the capacity to make their own decisions is that it respects patients’ humanity. In this view, withholding treatment from persons without decision-making capacity is neither compassionate nor right. After all, patients with untreated mental illness receiving competency restoration services are often suffering both from the inability to understand their situation and from the symptoms of their illness.¹⁵

Outpatient commitment as an expression of the least restrictive alternative. Legal oversight of inpatient commitment and the least restrictive alternative ensure that the law is appropriately limited to specific populations with specific problems that can be managed in a clinical setting. The legal rules place the burden of arranging alternatives on the state so that individuals have access to the complete set of options that support individual liberty. Outpatient commitment—in which courts order outpatient treatment under threat of rehospitalization or rehearing—is a specific version of the least restrictive alternative.¹⁶ Yet even this less restrictive alternative has been criticized for its broader application to people of color.¹⁷

Treating Defendants

Aid-in-sentencing. Aid-in-sentencing evaluations allow the law to appeal to values of care for defendants undergoing sentencing. Exploring defendants’ life circumstances and clinical history helps courts assess the harm a correctional setting can do and is a significant intervention for vulnerable persons diagnosed with mental illness. Psychiatrists can offer a variety of recommendations to place or treat defendants experiencing mental illness. These lesser-known evaluations join insanity defenses as an example of attempts to treat defendants with the compassion due their condition—a condition that may not allow them to shoulder responsibility for their actions.

Diversion. Diversion encompasses several compassionate substitutes for the traditional court model. Drug courts, **mental health courts**, and Veterans’ courts are compassionate means of mitigating potentially harmful effects of the judicial system on persons with treatable conditions. Drug courts, for example, use the leverage of pending charges to compel treatment, offering the opportunity for recovery rather than punishment. Graduation ceremonies from drug courts are often moving affairs, attended by family members, court officers, and recovery professionals.

Conclusion

The cultural formulation of forensic ethics, narrative ethics, the doctrine of therapeutic jurisprudence, professionalism, clinical consultation to the courts, and diversion efforts tie compassion tightly to the law through the fundamental dignity of persons. Compassion is consequently an influential component of a judicial system that strives to do more than provide mere procedures that distinguish guilty from not guilty, competent from incompetent, dangerous from harmless. There is an entire framework for using clinical interventions to restore competence, treat underlying mental illness, and return justice-involved persons to their communities. At a time when compassion can be difficult to find in law and its enforcement, these mechanisms can remind us of humanistic influences on society's behavior.

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Citation

AMA J Ethics. 2021;23(4):E335-339.

DOI

10.1001/amajethics.2021.335.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

POLICY FORUM: PEER-REVIEWED ARTICLE

When Structural Inequity Is Ubiquitous, Can Force Ever Be Compassionate?

Sriya Bhattacharyya, PhD, Aaron S. Breslow, PhD, Jianee Carrasco, and Benjamin Cook, PhD, MPH

Abstract

This article contextualizes and challenges race, class, and gender inequity in psychiatric use of force. In particular, this article examines (1) how uses of force—seclusion, restraint, compulsion—have been codified in policy and law, (2) inequity in force utilization, and (3) connections between systemic oppression and individuals' responses—including fear and retraumatization—to feeling threatened by force in clinical settings. This article proposes multilevel strategies to abolish inequity in uses of force in clinical settings and questions whether it is ever possible to use force compassionately where inequity persists.

Introduction

Force utilization in US mental health care settings reifies structural inequity and must be abolished. Evidence for this stance includes myriad harms of force^{1,2,3,4,5} and the experience of individuals living with mental illnesses who, for over a decade, have decried uses of force in carceral, emergency department, and psychiatric settings.^{6,7,8,9} Force utilization in health care is not only widely documented as a source of harm but also inequitably applied based on race, gender, age, and diagnostic history.^{9,10,11,12} This article contextualizes uses of force through intergroup threat theory, argues that the possibility for compassionate intention in the use of force is extremely remote amidst pervasive inequity, and suggests how to render force obsolete.

Contextualizing Force

The COVID-19 pandemic has disproportionately affected people with mental illnesses¹³ and Black people¹⁴ and exacerbated extant conditions of police brutality, **anti-Black racism**, and carceral violence.^{15,16} Approximately one-third to one-half of all people killed by police have a disability.¹⁷ As movements for racial justice build, clinicians in hospital, nursing home, community health, and private psychiatric settings must interrogate how force reifies structural violence and oppression. Force can be applied mechanically, pharmacologically, or legally and implemented by *seclusion* (ie, isolating a person from staff and patients),¹⁸ *restraint* (ie, **physically limiting a person's mobility** through manual holds, mechanical tools, or pharmacologic agents),¹⁹ and *compulsion* (ie, involuntarily hospitalizing and treating a person).²⁰

Force is typically utilized to prevent people from harming themselves or others, especially when a person's **decision-making capacity is compromised**. It is most frequently used in emergency departments and inpatient psychiatric units to promote safety and should be regarded as a "last resort," according to the American Psychiatric Association,²¹ Recovery Innovations' "no force first" policy,²² and the Joint Commission.²³ Yet, in one study of 317 US hospitals, monthly administrative data indicated no change in frequency of force use between 2007-2011 and 2012-2013, although there was a nonsignificant decrease in the average length of episode.²⁴ Reforms in force implementation practices have shown some success.^{1,25} It remains ethically important, however, to imagine health care *without* force practices at all.

Reformers argue that force might be needed in extraordinary circumstances, such as when patients decompensate to a point at which they threaten their own or others' safety. Similarly, those calling for compassionate use of force argue that force practices can be ethically implemented when collaboratively considered, prior to need for their implementation. Indeed, individuals with recurrent conditions can request that force be used (ie, if and when their condition worsens to the point at which they lack insight or capacity) by psychiatric advance care planning, sometimes documented as "Ulysses contracts."^{26,27,28}

Force Equity?

Whether force can be compassionate is controversial. Mental Health America (ie, position statements 22 and 24)^{29,30} and the American Psychiatric Nurses Association³¹ decry its use outright. Abolition of force is perhaps most easily justifiable in terms of its inequitable implementation. Across critical incident studies, quality surveys, and meta-analyses, seclusion and restraint are widely documented as inequitably administered to men³ or to people who are Black, unemployed, or homeless or who have been previously hospitalized and had longer hospital stays.^{24,32} Among women, Black women and those with prior interactions with police are more likely to experience involuntary interventions.³³ These patterns persist in children's inpatient psychiatry settings, where younger age and Black race are associated with seclusion,³⁴ and in emergency departments, where Black patients are more likely than White patients to be restrained.¹⁰ We acknowledge that staff and patients must be kept safe, but we must also acknowledge that the pervasiveness of anti-Black racism means our Black patients are more likely to be subject to force and its iatrogenic harms. Indeed, the American Psychiatric Association in January 2021 issued an "Apology to Black, Indigenous and People of Color" for supporting structural racism in psychiatry.³⁵ Although it did not mention force per se, the statement decries "abusive treatment" as well as racial inequities in clinical treatment.

Intergroup threat theory can help us understand how inequitable application of force transpires in health care settings. Intergroup threat theory suggests that members of certain groups perceive members of other groups as threats simply due to their group membership and the ways we are socialized to fear the "other." The perception of threat contributes to disparate force utilization, especially among people who have experienced racism. In hostile or violent interactions, people can respond to feeling threatened by expressing negative attitudes, biases, verbal and nonverbal behaviors, and aggression³⁶ and with "fight, flight, or freeze" responses.³⁷ Clinicians, even clinicians of color, who have internalized White supremacy can express pro-White biases in their responses to Black patients, whom they view as threatening, and can engage "fight" responses that include implementing force. Of course, patients also respond to

feeling threatened. People who have experienced negative bias or even covertly racist incidents can experience trauma.³⁸ Accordingly, when people feel harmed within a hostile, restrictive environment dictated by punishment and control, they can respond behaviorally and in ways that can be perceived by others as threatening. Violence begets violence,³⁹ exacerbating historically entrenched oppression in clinical settings that recurs at micro, meso, and macro levels.⁴⁰ At the micro (personal) level, inequity can manifest in clinician bias^{41,42} and be expressed in elevated rates of psychiatric diagnoses among people of color^{43,45,45} and clinicians' negative feelings toward people of color who are or are **perceived as aggressive**.⁴⁶ At the meso (community) level, inequity can manifest in health care organizations' force protocols' neglect of how aggression and anger might be reasonable responses to experiences of systemic oppression or a specific threat of harm.^{47,48} And, at the macro (social, cultural) level, inequity manifests in greater police brutality against people with disabilities and people of color.⁴⁹

Where Inequity Persists, Abolition

Calls for abolition of force in mental health care are not new. In the mid-1800s, proponents of "moral treatment" for psychiatric patients advocated for the end of force, particularly restraint.³¹ In the 21st century, clinicians began to argue that restraint use was not evidence based and was counter-therapeutic.¹ Multidisciplinary, global efforts to prevent force utilization with aggressive patients continue, and one study assessing responses to patient violence in psychiatric settings across the European Union prioritized reducing force.⁵⁰ The World Health Organization also argues that seclusion and restraint are neither evidence based nor therapeutic and calls for regulatory changes and abolition of these practices.⁴⁷

As psychologists and health services researchers who have studied, been complicit in, and resisted using force to treat patients, we recognize the complexity in rendering seclusion, restraint, and compulsion obsolete. We acknowledge important work being done to reform these force practices, which call for equitable, compassionate force implementation. The New York State Office of Mental Health (NYSOMH), for example, requires that force (a) can only be utilized as a last resort to prevent injury, (b) can only be valid for 2 hours by a physician's order, (c) cannot be used as punishment, (d) must include regular vital monitoring procedures, (e) must not be used excessively, and (f) must be followed by a debrief on how to prevent future uses of force.⁵¹ Notably absent from the NYSOMH website, however, are guidelines for mitigating inequity or creating a path toward rendering force obsolete.⁵² Two facts are undeniable: (1) force is utilized disproportionately on men, Black people, unemployed people, and homeless people and disproportionately harms Black men^{3,10,24,32,33,34}; and (2) multiple advocacy groups decry the use of force.^{6,7,8,29,30,31,53,54} Thus, we argue for the immediate end to seclusion, restraint, and compulsion.

Because some people with mental illnesses might harm themselves or others, we acknowledge that there are cases in which *not* using force might be considered neglect or abuse. Although we recognize the merits of this perspective, we call for consideration of feminist accounts of oppression that attribute the poorer psychiatric outcomes of some patients to their lack of power and agency.⁵⁵ Feminist psychiatric ethical and clinical approaches suggest that restoring power and agency to patients is a key mechanism of therapeutic action that mitigates the need for seclusion, restraints, or compulsion and that can help end what have been called "aggression-coercion cycles."⁵⁶

There are several ways clinicians, staff, and organizations can mitigate and seek to eliminate inequity in force implementation, with the primary goal of abolishing seclusion, restraint, and compulsion in health care settings.

1. *Commit to anti-racist practice.* Interrogate internalized racism,⁵⁷ deconstruct White privilege,⁵⁸ and practice decolonization⁵⁹ to uproot conditions that necessitate the use of force.
2. *Draw on intergroup threat theory to discern, mitigate, and de-escalate racialized responses to feeling threatened.*
3. *Be accountable in relationships and create space for reflection and analysis to shift the sociocultural dynamics in health care settings.* Provide trauma-informed care to patients.⁶⁰ Provide time and space for clinicians to reflect on and be accountable for racist beliefs and to center the resilience of people of color.⁵⁶
4. *Promote health care organizational change.* Implement alternatives to the use of force, do not invite police or security personnel to patient care settings, de-escalate conflict,⁶¹ and focus on restorative justice after conflict.⁶² Collect data about force utilization inequity. Hire clinicians who represent patient populations.
5. *Partner with mental health community and advocacy groups.* For example, through MAD PRIDE,⁵¹ Fireweed Collective,⁵² and the Hearing Voices Network⁶³ learn about the call to demedicalize diversity in mental illness experiences. Support interventions that reduce the need for involuntary admission.^{52,64} Join extant movements for institutional accountability.
6. *Promote abolition of force where inequity persists.* In line with a statement from Mental Health America,³⁰ work to identify and uproot conditions contributing to inequity.

Conclusion

As health care professionals, it is critical that we identify the root causes of inequity in force use in clinical settings. Some professionals in health care and in law enforcement use the language of compassion to justify using force in their practices, so we must be wary of when compassionate intention actually manifests as racism, violence, and dehumanization. It is our duty to strive to share power, promote liberation, question impulses to control, and render force use on anyone obsolete.

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Citation

AMA J Ethics. 2021;23(4):E340-348.

DOI

10.1001/amajethics.2021.340.

Acknowledgements

We would like to thank and uplift the work of activists, including those from the Fireweed Collective and the Movement for Black Lives.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

AMA Journal of Ethics®

April 2021, Volume 23, Number 4: E349-361

ART OF MEDICINE

COVID Care in Color

Valerie Tarsia, PA-C

Abstract

This group of paintings portrays the beauty and strength of frontline clinicians in a hectic emergency room during the COVID-19 pandemic. Head-to-toe personal protective equipment covers their fear. Vibrant colors and strange perspectives help question the reality through which they and their patients lived.

Figure 1. COVID ENT Exam, 2020



Media

Acrylic on canvas, 16" x 20".

Caption

During the worst peaks of the COVID-19 pandemic, I painted frontline heroes gowned to treat a dreadful explosion of sick patients.

Figure 2. *Reflection*, 2020



Media

Acrylic on canvas, 16" x 20".

Caption

This self-portrait reveals my reflection on a 12-hour work shift and on protecting my family. Even after our skin peels off the bridge of our noses, we in the emergency room take responsibility for our physical and **emotional stress** and practice repetitive routines

to contain the virus. Beyond the skin layer, we are all the same, so I layered saturated yellow, cerulean blues, and magenta to create a multidimensional pallet.

Figure 3. *Respirator Perspective*, 2020



Media

Acrylic on canvas, 16" x 20".

Caption

Fear of an unknown contagion is dreadful, especially without proper personal protective equipment (PPE), so at the beginning of the pandemic, when there was conflicting information on how and when to use our PPE, we relied on each other for support and protection. Now, we are more versatile and confident. Because N95 masks were selling

online at triple the normal price, we cold-called the nearest hardware stores every morning to occasionally get a lead about acquiring reusable respirators for members of the team. We wear single-use masks for 12 hours.

Figure 4. *Take a Deep Breath*, 2020



Media

Acrylic on canvas, 16" x 20".

Caption

Sometimes we wear so much gear that, from a patient's point of view, we look somewhat like a space person approaching. With a shortage of PPE, civilian-donated ski

goggles helped keep us safe. Wearing this garb is now routine for us. But from a delirious febrile patient's perspective, it's certainly not routine to hear a Darth Vader-like muffled voice say, "Your lungs sound clear."

Figure 5. *Neon Suture*, 2020



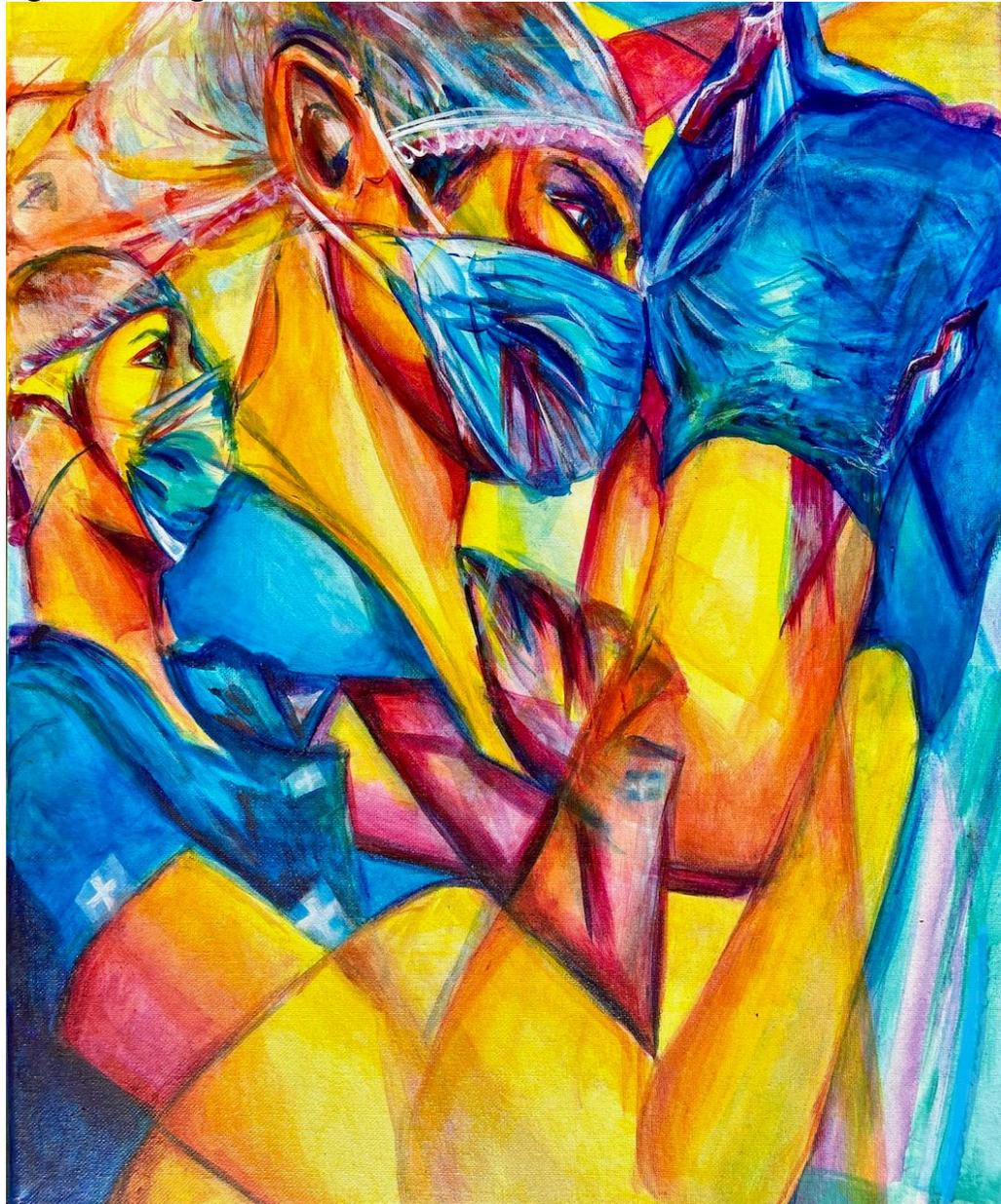
Media

Acrylic on canvas, 16" x 20".

Caption

This is a mirror image of personal space encroaching and superimposing on itself. Two figures are not quite separate. Wavelengths of light bounce, and neon colors attract a viewer's attention to a seasoned physician assistant's agile hands.

Figure 6. *Moving Forward*, 2020



Media

Acrylic on canvas, 16" x 20"

Caption

This portrait, representing a group of “masked heroes,” blends a primary color pallet to create movement. Short of PPE, we tried wearing laminated photos with a sliver of our eyes visible to reassure isolated patients. Patients without family members present just had us, our compassion, smiles, and altruism.

Figure 7. *Emergency Room*, 2020



Media

Acrylic on canvas, 30" x 40".

Caption

Pulling back from a bustling emergency room scene, one can see, through a fog of anxiety, a unified symphony. Each individual medical professional performs a task to try to save the lives of patients in an **overwhelmed hospital system**.

Figure 8. *Diversity in Medical Professionals, 2012-2020*



Media

Acrylic on canvas, 24" x 36".

Caption

Whether regular emergency front liners or specialists who dove into the front lines, we all wondered, *Will we have mask-less, fear-less, expression-full patient-clinician contact experiences again?*

Figure 9. *Dimensional Doctor*, 2020



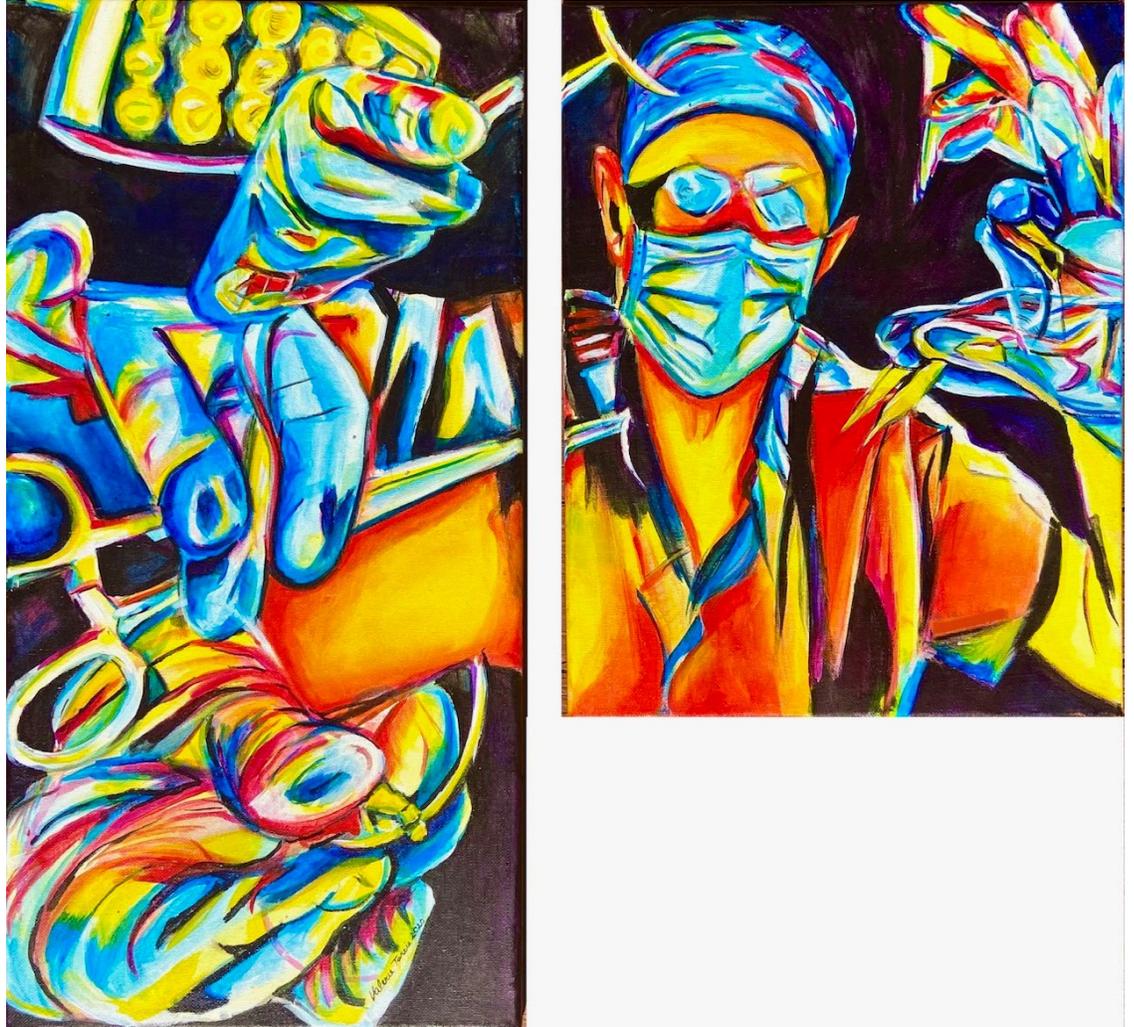
Media

Acrylic on canvas, 16" x 20".

Caption

Bright colors and gold trim represent the multifaceted personalities, good will, and courage of emergency department workers, who keep each other sane and use humor to lighten a dramatic load as they perform their tasks.

Figure 10. *Diptych of Closing the Wound*, 2020



Media

Acrylic on canvas, 10" x 20" and 11" x14".

Caption

The confidence of this physician assistant is seen in his swift movements. With fluidity in tying each suture knot, he closes a wound.

Figure 11. *Aortic Vascular Surgery, 2020*



Media

Acrylic on canvas, 24" x 36".

Caption

Specialty surgeries were halted during the pandemic closures, and surgical teams were diverted to caring for patients in intensive care units (ICUs). Some medical professionals lacked experience treating intubated, dying patients, but they quickly adjusted.

Figure 12. *Under the Mask*, 2020



Media

Acrylic on canvas, 11" x 14".

Caption

Imagine after training in surgery for 10 years, you assume responsibility for treating COVID ICU patients. You then contract and struggle with COVID. A mirror here is not used for vanity but to reflect on who we are beneath our masks. Beyond questioning the **nightmare of the moment**, these professionals see their strength and beauty.

Valerie Tarsia, PA-C has been working with a Bronx emergency room team for 6 years and painting for 25 years.

Citation

AMA J Ethics. 2021;23(4):E349-361.

DOI

10.1001/amajethics.2021.349.

Acknowledgements

I wish to thank every medical professional, with special thanks to the ones with whom I work, who are strong, very much appreciated, and supportive.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

AMA Journal of Ethics®

April 2021, Volume 23, Number 4: E362-363

ART OF MEDICINE

Going Up or Down?

Katelyn Norman, MD

Abstract

This oil painting of a crowded elevator carriage suggests our numerous shared uncertainties, risk of exposure to the SARS-CoV-2 virus, and lack of knowledge about our and others' risk of death from COVID-19.

Personal protective equipment is uncomfortable, but it's less uncomfortable, perhaps, than knowing our safety depends so much on others' behaviors.

Figure. *The Elevator*



Media

Oil on canvas, 24" x 36".

Caption

In this crowded hospital elevator, the doors have either just opened or are about to close, and the carriage is either going up or down. Occupants include patients, visitors, clinicians, and administrators who are (or are not) donning various kinds of personal protective equipment; proximity both unites and threatens them. *The Elevator* is a reflection on our discomfort with **depending on others** to express consideration and respect for our safety and with their dependence on us. We're all in this together, but some among us have more to lose.

Katelyn Norman, MD is the chief resident of the Yale-Waterbury Internal Medicine Residency Program in Waterbury, Connecticut. She received a BFA degree in studio art and an MD degree from the Frank H. Netter MD School of Medicine at Quinnipiac University. In addition to serving as chief resident, she is also co-chair of the ethics committee at her institution.

Citation

AMA J Ethics. 2021;23(4):E362-363.

DOI

10.1001/amajethics.2021.362.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

April 2021, Volume 23, Number 4: E364-368

VIEWPOINT: PEER-REVIEWED ARTICLE

Ending Restraint of Incarcerated Individuals Giving Birth

Kayla Tabari House, RN, MBE, Sarah Kelley, David N. Sontag, JD, MBE, and Louise P. King, MD, JD

Abstract

Advocates have long suggested making shackling incarcerated people during childbirth illegal. Yet exceptions would likely still allow prison personnel to implement restraint and leave clinicians no course for freeing a patient. This article argues that clinicians' assessments of laboring individuals' clinical needs must be prioritized, ethically and legally. This article also explains that, without strong policies in place, some clinicians will not feel empowered to demand that a patient be freed during labor. Beyond prohibiting restraint of laboring individuals, health care organizations must support clinicians seeking to execute their ethical duties to care well and justly for patients. Toward this end, this article proposes a model policy.

Why Is This Done, Why Stop?

Shackling incarcerated individuals giving birth in hospitals has 2 origins: protecting the public by preventing an escape and protecting health care worker safety. Jails and prisons are responsible for actions of individuals under their control and can be held liable for harm caused by those individuals if it is determined that jail or prison personnel acted negligently (ie, failing to secure them). During 2016-2017, 753 individuals in the United States gave birth in hospitals while incarcerated.¹ It is not known precisely how many **incarcerated individuals giving birth** were chemically or physically restrained during their hospitalizations, but restraint is common.² There are 3 clear reasons this practice should end: (1) physical demands of labor and delivery make escape attempts extremely unlikely, (2) no pregnant or laboring incarcerated individual has ever been documented as having escaped a hospital,³ and (3) most women experiencing incarceration "are not violent offenders, so restraining them to prevent attacks on workers is largely unnecessary."⁴

We argue that clinicians must prioritize patients' best clinical and ethical interests and that organizations' policies must support clinicians trying to do so. Justice and nonmaleficence, other cornerstone values of health care professionalism, require that organizations prohibit restraint of individuals giving birth on their premises and that organizational policies be equitably administered. After discussing current policy and law on restraint of laboring individuals, we (1) propose a model policy for health care

organizations to adapt and (2) suggest that organizational leaders educate clinicians on relevant laws that recognize their authority to protect pregnant individuals experiencing incarceration.

Prioritizing Safety and Equity

Manacled or fettered incarcerated individuals giving birth in hospitals is ethically unacceptable because it undermines safe, compassionate birth practice and because **people of color** are disproportionately more likely to be subjected to it.⁵ Carolyn Sufrin, a medical anthropologist and obstetrician-gynecologist explains: “In labor, emergencies arise unexpectedly. We might need to do an emergency C-section if there are signs of distress or the baby’s shoulder could get stuck in the birth canal. When one of these emergencies arises, as a healthcare professional, we need to focus on our patient, not on asking a guard to unshackle her.”⁶ The American Psychological Association supports protecting incarcerated individuals who are pregnant or giving birth, citing numerous states’ indiscriminate use of restraints.⁷

There can be cases in which restraint use is ethically and clinically appropriate, and there are some cases in which restraint can be a compassionate thing to do, but restraint as a blanket policy is harmful and unacceptable. In hospital settings, only clinicians should determine whether and when restraint is indicated for a specific patient at a specific time. Clinicians who work with individuals giving birth are practiced in assessing a patient’s need for restraint interventions and balancing such need against risks of harm to her and her child.⁸ Clinicians are also trained to balance multiple ethical and clinical goals when managing a patient’s care and to respond to some agitated patients without using restraints.

Current Law

Although some advocates have suggested outlawing shackling, laws written to ban shackling incarcerated people giving birth frequently contain exceptions that preserve prison personnel’s authority to restrain patients—even in hospital settings—despite clinicians’ requests to free a patient for safety, equity, or adherence to standard practice. Some laws seem to recognize that people who are pregnant and incarcerated pose small risk of escape or harm to others. Laws governing federal prisons⁹ and laws governing prisons and jails in 20 states¹⁰ specify that restraining pregnant individuals is prohibited and that prison personnel must defer to a clinical team. These laws do not ban use of restraints by prison personnel but recognize clinicians’ authority in protecting individuals in labor. Clinicians must be educated about these laws and what they say about their roles, authority, and duties, since clinicians who do not know they can **order restraint removal** likely will not do so.¹¹

Equity and Movement

Many individuals in labor often sway back and forth, stand, crouch, pace, and sit in a variety of positions in order to bear intense pain, so unnecessary restraint can be traumatizing.¹² We must interrogate unnecessary risk imposition and ask, *Who exactly is being harmed?* Black women are incarcerated at a rate that is almost 3 times higher than White women.⁵ Accordingly, the practice of handcuffing pregnant patients will disproportionately traumatize (or retraumatize) Black people. The American Civil Liberties Union and the American College of Obstetricians and Gynecologists do not support routine shackling of pregnant individuals who are incarcerated^{2,3} because it is dangerous, unduly restricts movement, and can increase life-threatening risk (ie, for blood clots).¹³

Further study on health risks of shackling during childbirth is needed. The US federal government does not require prisons or jails to collect data about pregnancy and birth among women experiencing incarceration,^{7,14} and this should change, given the ease with which such data could be maintained.¹ But absence of data does not make it unreasonable to suppose that restraints could generate worse outcomes for individuals experiencing incarceration, since it is known that negative birth experiences can affect parent-newborn bonding.³ We encourage legislation requiring data collection, especially about race.

Toward Just Organizational Policy

Clinicians and organizations must ensure that birth is as safe and patient centered as possible for all patients. All patients deserve standard prenatal care, prenatal education, parenting classes, and other resources.¹⁶ When a woman arrives at a hospital in active labor, the primary focus should be on ensuring her and her child's safety. Organizational policies should comply with applicable federal and state law, be concise and easily readable, use language that reinforces all patients' personhood and dignity, and limit exceptions in accordance with 3 features of model policy:

1. A pregnant patient in any stage of delivery may not be placed in restraints at any time.
2. A patient in postdelivery recuperation shall not be placed in restraints, except under extraordinary circumstances (ie, the patient presents immediate, serious threat to self or others or presents immediate, credible risk of escape that cannot be curtailed by other measures). If clinicians determine that restraints must be used, restraints shall be the least restrictive and most reasonable available.
3. Leg or waist restraints shall not be used on a pregnant or postpartum patient.

Clinicians have duties to assume active roles in ending shackling, which compromises safety and compassion, inconsistent with federal and many states' laws. Health care organizations must act to educate and support clinicians looking out for their patients' interests and seeking to provide equitable care.

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Citation

AMA J Ethics. 2021;23(4):E364-368.

DOI

10.1001/amajethics.2021.364.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

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AMA Journal of Ethics®

April 2021, Volume 23, Number 4: E369-370

CME MODULE

What Can Clinicians Learn From Caregiving and Research in Ghettos and Camps of Nazi-Occupied Europe?

Tessa Chelouche, MD and Matthew K. Wynia, MD, MPH

This course will focus on the clinician teachers and researchers in the Warsaw Ghetto. We will delve into how their resilience and research influences health care workers today.

To claim one AMA PRA Category 1 Credit™ for the CME activity associated with this article, you must do the following: (1) read this article in its entirety, (2) answer at least 80 percent of the quiz questions correctly, and (3) complete an evaluation. The quiz, evaluation, and form for claiming AMA PRA Category 1 Credit™ are available through the [AMA Ed Hub™](#).

Tessa Chelouche, MD is a family physician in Israel, where she also serves as co-chair of the Department of Bioethics and the Holocaust of the UNESCO Chair of Bioethics, Haifa. She is codirector of the Maimonides Institute for Medicine, Ethics and the Holocaust and has been a lecturer for a preclinical course on medicine and the Holocaust as a member of the Rappaport Faculty of Medicine at the Technion Institute for the past 20 years. She coauthored the *Casebook on Bioethics and the Holocaust* (UNESCO Chair in Bioethics, 2013) and has published articles and presented at numerous national and international conferences on topics involving medicine, ethics, and the Holocaust.

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Citation

AMA J Ethics. 2021;23(4):E369-370.

DOI

10.1001/amajethics.2021.369.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

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