

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Should Dignity Preservation Be a Precondition for Safety and a Design Priority for Healing in Inpatient Psychiatry Spaces?

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Abstract

Therapeutic security in inpatient psychiatric settings requires careful planning and implementation if it is to support patients' safety and dignity. This commentary on a case considers patients' dignity experiences when restrictions on their freedom are used to keep them safe.

Case

BL is a 48-year-old woman suffering an initial episode of severe depression. She has been contemplating ending her life and, at her sister's urging, agrees to voluntary inpatient admission to be treated for depression. To her horror, she is asked to remove and relinquish her bra, her drawstring sweatpants, and her shoelaces, since straps and strings are viewed as a ligature risk. She is admitted, alone, and feels stripped and ashamed. Wearing no bra and ill-fitting hospital-issued clothing and footwear, she meets Dr Psych for the first time.

Commentary

This case demonstrates a common feature of inpatient psychiatric services. It is often the policy of inpatient units that patients are required, on admission, to relinquish items of clothing and property that are deemed to pose a potential risk of harm. This policy is ostensibly in the interest of patient safety because drawstrings, belts, and shoelaces can be used as ligatures. However, given the significant potential for humiliation and loss of freedom in such a practice, it is something that should be subject to discussion and review. As with many contentious issues in clinical practice, evaluation through the prism of medical ethics can bring new perspectives. Weighing the ethical risks of these types of restrictive practices against potential safety benefits is important in ensuring that the environment of a modern psychiatric inpatient unit is conducive to both healing and dignity, which are by no means separate considerations.

In this discussion, we consider whether patients can feel safe without retaining a sense of dignity, how clinicians should respond to patients in health care spaces that patients experience as neither safe nor healing, whether undermining of patient dignity in these spaces should be considered as iatrogenic harm, how clinicians' perspectives on safety

should be weighed against patients' experiences of dignity, and approaches to risk management that may promote dignity in the psychiatric inpatient setting.

Safety Without Dignity?

A narrow definition of safety as protection from physical danger, risk, or injury can disconnect the concept of safety from that of maintaining dignity. However, the World Health Organization, which defines safety as "the reduction of risk of unnecessary harm to an acceptable minimum," specifically includes emotional harm in its conceptual framework of patient safety.¹ Given that harm to human dignity is an example of emotional harm,² in a health care context patient safety and dignity are interlinked.

Physical safety is of clear importance for patients in a psychiatric inpatient environment.³ Patients, their families, regulatory bodies, and society as a whole have the expectation that harm to self and others should be prevented in an inpatient setting. Inpatient suicide is listed as a "never event" (also called a "sentinel event" or a "serious reportable event") in health care services the world over. Nevertheless, inpatient suicides occur. Rates vary, but one 2015 meta-analysis of 44 studies based on data from the United States, Europe, and Australasia found the pooled estimate of suicide rates per 100 000 inpatient years to be 147.⁴ Prevalence estimates of suicide attempts and other acts of nonfatal self-harm are even more variable^{5,6} due to methodological differences, such as sampling and assessment strategies.⁷ Reported rates of nonsuicidal self-injury among psychiatric inpatients range from 4% to 70%.⁵ A review article of 43 studies found a mean event rate of 3.2 attempted suicides per 100 psychiatric admissions per month.⁶ The most common method of completed suicide in hospital is via ligature.⁸ While much is done to remove ligature points from inpatient units, strangulation can occur even without identifiable ligature points. The apparent need to remove potential sources of ligature from patients on their arrival to an inpatient unit is therefore embedded in many admission protocols.

Although this practice is ethically justifiable to uphold patient safety, recognition and communication of its potential emotional impact is crucial to minimize the stigmatization and distress it causes. Good communication, wherein patients feel "heard" by staff, is an important feature of dignity experience.⁹ Patients' perceptions of the fairness of coercive interventions during their treatment is a stronger predictor of their attitude towards psychiatric care than the number of coercive interventions they experienced.¹⁰

There are ethical complexities that need to be navigated in each individual case and across each inpatient unit. For instance, there is a clear tension between upholding the principles of beneficence (reducing risk and providing care) and nonmaleficence (avoiding harmful loss of dignity) while also respecting the principle of autonomy (the right to behave as one chooses). Balancing these principles becomes yet more complex when one considers that, in a congregated environment, even if a given patient presents a low risk of harm, the patient's drawstrings, belts, and shoelaces might be obtained by another patient who is at higher risk. Placing limitations on a patient not for their own safety, but for the safety of other patients, raises ethical questions of fairness and proportionality.¹¹ Balancing the rights of the individual with the rights of others requires managing inpatient units with an awareness of the complex, changing nature of risk and continually weighing considerations of dignity, beneficence, nonmaleficence, and autonomy at individual and group levels.

Safe, Healing Spaces

To heal is to “make whole or ... restore to health.”¹² In relation to psychiatric conditions, healing may entail the resolution of psychopathological symptoms or the restoration of subjective well-being and observed functionality. In the above vignette, a woman who has self-presented to the hospital for treatment of a mood disorder is met with an institutional practice—removing her bra, sweatpants, and shoelaces before being interviewed by the psychiatrist—that results in her experiencing shame and horror. This practice, on its face, is in direct opposition to instilling a sense of safety and promoting healing. Patients’ subjective experience of coercion is negatively correlated with their perception of dignity.¹³ In addition, **environmental restrictions** are associated with increased risk of self-harm.^{5,14} More generally, factors such as feeling controlled by staff, having requests denied by staff, and experiencing restrictive practices are antecedents to self-harm in psychiatric inpatient units.⁶ Therefore, strategies such as those outlined in the above vignette, while aimed at reducing risk of self-harm or suicide among psychiatric inpatients, may paradoxically have the opposite effect.

Patients’ relationships with staff and their sense of being treated as an ordinary human being are key elements of the patient experience of dignity in psychiatric inpatient settings.¹⁵ Conversely, negative staff attitudes are a crucial component in patients’ experience of humiliation.¹⁶ From a sociological perspective, a culture of respect and dignity promotes prosocial behavior in a group environment.¹⁷ Therefore, the importance of clinicians responding to patients in a dignity-promoting manner cannot be overstated.

Undermined Dignity as Iatrogenic Harm

The above vignette clearly outlines the negative emotional impact of removing personal items from patients on admission to a psychiatric unit. While this practice is aimed at reducing risk of self-harm, it nonetheless can increase perceived stigma, a factor that has been demonstrated to increase suicidality.¹⁸ Many of the restrictions placed on patients in the name of safety are recommended and enforced by regulatory bodies, whose role it is to minimize harm in health care environments. If one does not consider reduction of privacy or undermining of dignity as a harm, then there is little reason to limit the restrictions placed on patients in inpatient units. Yet this reasoning is clearly unacceptable: undermining patient dignity is an iatrogenic harm, albeit one that is often systemic in origin rather than rooted in specific actions of health care staff at the individual level.

Complete elimination of risk of self-harm in an inpatient setting is impossible, especially given that an item as seemingly innocuous as a t-shirt can be used to self-strangulate, even by a patient under close observation in a secure setting.¹⁹ Close nursing observation is an important factor in reducing risk of suicide in inpatient settings, but it does not entirely eliminate risk (as one study found that 18%²⁰ and another that 51%²¹ of inpatient suicides occur in patients on intermittent observation, while 3%²⁰ to 9%²² of inpatient suicides occur in patients on constant observation). Nevertheless, given the high rates of self-injury among people admitted to psychiatric inpatient units,⁶ strategies to reduce risk of self-harm are certainly warranted and required. In order to strike a balance between protection from harm and personal freedom, regulators must consider that undermining human dignity is a potential **iatrogenic harm associated with some restrictions** and safety measures. Recognition of this fact by regulators, and associated limitations on and monitoring of restrictive practices, is required if psychiatric inpatient environments are to be both safe and healing for patients.

Perceptions of Coercive Practices in the Psychiatric Inpatient Setting

It is important to note that staff, as well as patients, may find practices that limit patient freedom distressing. A qualitative study of staff and patients in a psychiatric inpatient unit in Norway found that some staff perceived house rules and limitations on patients' behavior to be a violation of patient dignity.²³ However, many patients accept that some level of coercion is necessary when they are acutely unwell.²⁴ Limitations on patient freedom is therefore a nuanced issue that requires a considered approach.

Research consistently demonstrates that clinicians experience patient suicide as distressing, with emotional responses ranging from guilt and blame to shock, anger, sadness, and grief.^{25,26,27} It is understandable that clinicians and institutions wish to reduce the risk of suicide among inpatients as much as possible—firstly, in order to prevent harm coming to patients and, secondly, to avoid the implications (emotional, practical, legal, and otherwise) of an inpatient death. However, as described above, to attempt to entirely eliminate patients' risk of self-harm in psychiatric inpatient units solely by limiting access to means of self-harm would necessitate such intense restrictions and limitations that patient autonomy and dignity would be diminished to a harmful extent. Therefore, other strategies to reduce risk of suicide are required in order to promote both healing and safety.

Dignity-Conserving Risk Management Strategies

Besides limiting access to means of self-harm and implementing special observation, other strategies that have been recommended for suicide prevention among psychiatric patients include involvement of families, improving communication, and providing effective treatment of illness.^{3,28} In particular, active involvement of loved ones in patients' mental health care can lead to improved outcomes, including greater patient safety and engagement with care.^{29,30,31,32} In addition to helping keep patients safe and improving the quality of care planning,³¹ family involvement is significantly associated with attendance at follow-up appointments,^{30,31} potentially improving patient health outcomes in the longer term. Strengthening family members' involvement in care through their inclusion in communication has been identified as a strategy to reduce suicide risk³¹ while also empowering patients and their loved ones.³³

Conclusion

Therapeutic security in inpatient psychiatric settings requires careful design and planning if inpatient services are to optimize dignity as well as safety. The care environment is a key aspect of dignity preservation in psychiatric inpatient care,¹⁶ and a **positive physical environment** has been demonstrated to promote healing in a variety of medical settings.³⁴ Clinicians should also endeavor to actively involve patients' loved ones in their care and care planning, particularly in relation to communication of risk.

In considering issues of safety and healing in psychiatric environments, we recognize that—at times—certain restrictions on patients' freedom are necessary to prevent harm (for example, restricting the leave of involuntarily detained patients when there is a significant risk that the person would not return from leave). Nevertheless, certain house rules that are common in psychiatric inpatient settings and not strictly necessary for safety (for example, restricting access to mobile phones or designating bedrooms as off limits during the day) risk increasing patients' experience of coercion and contravening their dignity without proportionate benefit.^{13,15} It is therefore vital that restrictions on patients' freedom are limited to those that are essential, proportionate, and justifiable.

Additional strategies, such as involvement of families in care, fostering positive relationships with staff, and providing effective treatments for illness, are important adjuncts to measures that limit patient access to means of self-harm.

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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.