

Episode: *Author Interview: “How Inpatient Psychiatric Units Can Be Both Safe and Therapeutic”*

Guest: Matthew L. Edwards, MD

Host: Tim Hoff

Transcript: Cheryl Green

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[bright theme music]

[00:00:04] TIM HOFF: Welcome to another episode of the Author Interview series from the *American Medical Association Journal of Ethics*. I’m your host, Tim Hoff. This series provides an alternative way to access the interesting and important work being done by Journal contributors each month. Joining me on this episode is Dr Matthew Edwards, an assistant professor of psychiatry and an assistant training director of the General Psychiatry Residency Program in the Department of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine in Stanford, California, where he is also a faculty member of Stanford’s General Psychiatry Residency Program and Forensic Psychiatry Fellowship Program. He’s here to discuss his article, coauthored with Dr Nathaniel P. Morris, “*How Inpatient Psychiatric Units Can Be Both Safe and Therapeutic*,” in the March 2024 issue of the Journal, [Psychiatric Inpatient Environmental Architecture](#). Dr Edwards, thank you so much for being on the podcast. [music fades]

DR MATTHEW EDWARDS: Thank you for having me, Tim. It’s great to be here.

[00:01:01] HOFF: So, to begin with, what is the main ethics point of your article?

EDWARDS: We hope to effectively communicate the delicate balance that administrators, policymakers, clinicians, hospital staff, and regulatory agencies must strike between creating inpatient environments that ensure patients are safe and cared for but also maintain dignity, respect, and autonomy for patients. It is really driven out of a desire for respect for persons, even as there are ethical, legal, and other reasons to prioritize patient safety, and we hope to emphasize how these sparse and controlling environments can create particular pressures on individuals from specific populations. One of those populations includes individuals from racially and ethnically oppressed groups, and those persons are more likely to come into mental health care from involuntary routes, are more likely to have come into contact with the criminal legal system throughout their lives, and are more likely to have experienced trauma and systemic harms, and thus they may be more likely to experience distress or re-traumatization. And one of the reasons for this is that some facilities are so driven towards safety and harm prevention that they hardly resemble those therapeutic spaces they were initially intended to be, and bear a striking resemblance to carceral, jail, or justice settings.

[00:02:22] HOFF: And so, what do you see as the most important thing for health professions students and trainees to take from your article?

EDWARDS: That people remember both perspectives of this article, that is, not only the emphasis on safety in cases of self-harm, but also ways to mitigate and reduce potential harm and violence for other patients, for other visitors and patrons and staff. We wanted to convey a patient-centered perspective in this article, that is, patients are often the ones whose agency, autonomy, and freedoms are restricted in these environments. But it’s also important to note that these safety measures, and the environments in which patients are placed, are created in

such a way to ensure the safety of staff and personnel. So, we discussed the frequency of adverse events in these settings, and I think it's important to emphasize that these adverse events can lead to self-injury, injury of other patients in the hospital seeking recovery, but also to the staff and families of individuals who are in those spaces to seek recovery. And these decisions and pressures towards these environments are not always left to individual institutions. There are mandates and requirements that are put in place at a local, state, or federal level, and a failure to ensure those safeguards that could lead to harm can jeopardize an institution's ability to provide care, which may further reduce access to mental health care.

[00:03:44] HOFF: And finally, if you could add a point to this article that you didn't have the time or the space to fully explore, what would that be?

EDWARDS: I would add that data about adverse events is readily available. We are pretty good at—and perhaps because it's mandated—maintaining, reviewing, and acting on data that demonstrates the safety of our inpatient environments. These include frequencies of adverse events, near misses, safe reports, or other institution-specific safeguards that help ensure safety in specific situations. These typically reinforce what we describe as a safety funnel, those top-down pressures towards more sparse and controlling environments to ensure patient safety. But perhaps what we need as well is a shift in how we think and move, and a similar pressure that gets at measures of dignity, autonomy, agency in these environments. Ways to measure a person's access to freedoms and comforts and environments that reinforce that sense of dignity and wellbeing might be a good counterbalance to the pressures that drive us towards the safety funnel. [theme music returns]

[00:04:58] HOFF: Dr Edwards, thank you so much for your time on the podcast today, and thanks to you and your co-author for your contribution to the Journal this month.

EDWARDS: Thank you. Thank you so much.

HOFF: To read the full article, as well as the rest of this month's issue for free, visit our site, [journalofethics.org](http://journalofethics.org). We'll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics*.