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Autonomy vs Nonmaleficence

Should Patients' Boredom in Locked Inpatient Psychiatric Units Be Considered Iatrogenic Harm?

This case describes patient NM's request to be discharged from a psychiatric unit prior to her clinician's recommendation. NM, initially admitted for depression and suicidal thoughts, explains that the boredom and lack of activity in the unit are worsening her mental state. Although she actively participates in all groups that are offered, watches TV, and voices her need for more stimulating programs, she continues to request discharge, believing that increased activity at home will better support her mental health. This situation presents a clear ethical dilemma between autonomy and nonmaleficence. While NM has the right to make decisions about her care, the provider must weigh the potential harms of an early discharge, considering whether boredom constitutes an iatrogenic harm.

Autonomy is demonstrated through NM's clear and consistent request to leave the unit regardless of the provider's intended course of treatment. NM describes the hospital days as long and mentally draining and explains that although she has engaged in every opportunity offered to improve her condition, these efforts have done little to alleviate her boredom or uplift her mood. Nonmaleficence is reflected in the provider's reluctance to discharge NM too early, which could intensify her suicidal ideations or place her at a greater risk. However, prolonged, non-stimulating hospitalization may contribute to a sense of hopelessness, isolation or lack of purpose, which can aggravate the patient's symptoms. Although NM's mental illness might raise concerns about her capacity in making autonomous decisions, her ability to clearly

express her needs and participate in her treatment indicates sound judgement and insight. Since NM has demonstrated self-awareness and commitment to recovery, honoring her autonomy is not only ethically justified but may also be the safer option.

One might argue that releasing NM from the unit may be counterproductive, as her initial admission was prompted by active suicidal ideations. From a nonmaleficence perspective, the clinician may want to prioritize her safety above all, believing that the hospital offers a controlled environment for monitoring and intervention. However, this assumes that the intuitional setting is inherently neutral or protective. In this case, the setting of NM's recovery appears to be amplifying her condition. When confinement contributes to further harm, it calls into questions the assumption whether continued hospitalization aligns with the idea of nonmaleficence. Therefore, disregarding her autonomy could ultimately result in the very harm her doctor aims to avoid.

The provider should engage in clear and compassionate communication with the patient, ensuring the six elements of informed consent are thoroughly addressed. This includes confirming NM's mental capacity, her understanding of the risks and benefits, and how her preferences align with the overall goals of her treatment plan. Healing is unlikely to occur in an environment that undermines a patient's well-being. The provider can initiate a productive conversation to explore different methods to make hospitalization more tolerable, discuss strategies for managing recurring negative thoughts, and to establish a safety plan after discharge. Upholding NM's autonomy, with shared decision making, not only respects her rights but fosters greater trust in the health care system, allows her concerns to be heard and can be a more effective path to recovery.

References

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